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Operational Technics for Sheltered Work Programs

September, 1961 Volume XXII, No. 9

REHABILITATION LITERATURE

National Society for

Crippled Children and Adults

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REHABILITATION LITERATURE

Article of the Month

Operational Technics for Sheltered Work Programs

A Guide for Planning and Management

N. P. Smith

Part Two of Two Parts

PART II

Production Considerations

A SHELTERED WORKSHOP'S responsibility for observing good business practices continues after the field representative has brought in the orders or contracts and while the work is in process. The real responsibility for a good business policy rests squarely on the shoulders of the production personnel. Floor supervisors should understand the responsibility and its importance. In sheltered workshops production supervisors are drawn from many walks of life. Although their backgrounds may vary, they tend to be persons whose major inclination is toward a service relationship with people. As a consequence, even those whose background includes business or industry may lose sight of business concepts through concentrating on the needs of their clients. From personal experience, I know how the enriched environment of a rehabilitation center will erase one's industrial values. It can take considerable time to regain these values and to recognize their significance for our main objective.

Production Control

A workshop's loss of its customers through failing to meet delivery dates with a stipulated quality and quantity of work is secondary to another loss incurred thereby—the opportunity to provide a better quality of service to its rehabilitation clients. Vocationally speaking, the best job training is given by an efficiently run shop that consistently emphasizes the importance of good business and industrial practices. Mrs. W. H. Parker[1] asks if the sheltered workshop is a business or a charity and answers that it is both: it cannot operate without subsidy, but

About the Author . . .

Miss Smith is associated with the New York State Workmen's Compensation Board as a rehabilitation representative. During the years 1950-1953 she served as supervisor of the vocational project and as senior vocational counselor, Chicago Welfare Department. She received her M.A. degree from the University of Chicago in 1953 and studied rehabilitation counseling at New York University. In recent years she has been shop director, Baltimore League for Crippled Children and Adults; workshop coordinator of the Training Center and Workshop of the Association for the Help of Retarded Children, New York City; supervisor of the industrial homework department, which she established initially, of the Federation of the Handicapped, New York City; and director of vocational services, Burke Foundation, White Plains, N.Y. Miss Smith has several years' experience in vocational services and considerable background in industry and the trades.

This original article was written especially for Rehabilitation Literature.

without business it cannot exist. She also states that good business objectives can be attained by cutting down waste, keeping up production, and fulfilling contract specifications.

It is not uncommon for those of us in the production staff of sheltered workshops to feel we are serving two opposing masters. We are quite apt to see the industrial requirements of production as road blocks interfering with the needs of our clients. Such a viewpoint is not hard to understand, since work in a sheltered shop appeals exclusively to those primarily interested in people, who place high priority on human values. Is this viewpoint sound, however? It may be, if one thinks only in terms of the immediate situation. When one takes a long-range view of the goal and studies the road the client must travel to reach it, this viewpoint is quite unsound, particularly if the goal is a competitive job in industry.

About This Article

Miss Smith's article has been published in two parts. Part II appears in this issue and Part I appeared in the August issue of *Rehabilitation Literature.* Part II is devoted primarily to 1) *Production Control,* 2) *Constructive Supervision,* 3) *Setting Up the Job,* and 4) *Meeting Contract Commitments.* In Part I Miss Smith discussed the preproduction considerations of *Contract Procurement* and *Organizing the Physical Plant.*

Miss Smith plans to incorporate the present two-part article in an operational manual on sheltered workshops and home employment programs that will be published soon as an instructional text for professional courses of study and as a guide for personnel engaged in this area of vocational rehabilitation.

In learning to achieve competence at anything, we must have standards for measuring our present level of performance and determining what more is needed. Each person must be able to apply these measurements to himself before real learning is achieved. In preparing a client for a place in industry, no scale can equal the job specifications for quality and productivity as required by our contracts. Once we accept this truth we will no longer be serving two masters; we will recognize quality specifications and production demands for the valuable tools they are, tools that function best when given proper attention and respect.

Most sheltered workshops do not operate at a loss only because they employ marginal workers. We often lose sight of the savings possible through efficient operation. This may be due to the absence of the profit motive, but conscientious shops are motivated to reduce losses. The agency's subsidy is a valuable resource that, if saved through efficient management, can be used to buy better services for clients. More efficient methods are the object of a never-ending search in industry, where the only gain is an increase in profit. The value of efficient operation for sheltered workshops cannot be measured by the decrease in losses alone; a much more important value is the constructive influence it has in developing more competent workers, whose employability will be improved thereby.

When we wish to become more efficient, we cannot be general in our planning. Efficiency can result only from a careful study of specific aspects of our operations, as it is achieved by eliminating waste. We may waste time, or materials, or overhead. Waste of materials is usually obvious but waste in time or overhead is often not seen so easily. Wasting time is not defined as idleness alone; it is possible to be busy or to work hard while wasting time. Wasting overhead does not necessarily mean a too lavish use or abuse of supplies and equipment; it can mean an ineffective use of space and utilities or a poor selection of tools for the job.

Since efficient operation has long been carefully sought by industrialists, they have learned where to look for and how to go about eliminating waste. We can capitalize on their experience by studying some of their more important problem areas, such as:

1) Excessive materials handling due to:
   a) poorly organized storage
   b) poorly thought-out job processes
   c) inadequate equipment
2) Rework due to:
   a) poor training
   b) inadequate inspection
3) Job processes resulting in:
   a) waste motions
   b) extra materials handling
4) Tools, jigs, and fixtures requiring extra handling
5) Scheduling resulting in:
   a) waiting time
   b) unnecessary materials handling

Constructive Supervision

A primary consideration in the selection of production supervisors for sheltered workshops is personality. A warm, outgoing person who is interested in people and wishes to help them should be sought. Added to this may be requirements in professional training and industrial experience, or both. This is as it should be, because our major objective is service to people. It does not mean, however, that we can dispense with qualities that make for an effective industrial supervisor. What we are really seeking are the basic qualities of an adequate industrial supervisor plus a service personality. Admittedly, this is a tall order. It is, therefore, necessary to help our pro-

duction personnel by thorough orientation and a continuation of inservice training.

First, it might be well to consider some special requirements for sheltered shop supervisors. Our person who wishes to help people needs to be empathetic rather than sympathetic. He must recognize the tough job facing his client and encourage him to make the needed effort without being soft enough to accept mediocre attempts. Pity has no place in the rehabilitation process; it is a debilitating emotion that denies the client the dignity due him. Pity is an indulgence the conscientious supervisor will avoid because it confuses values and can result only in a poorer service. The supervisor who is sorry for his clients will hesitate to hurt their feelings by correcting them. This results in an overprotective environment that leads to unrealistic expectations. The supervisor who is empathetic, on the other hand, will not hesitate to make realistic corrections and demands. His approach will not be blunt or unkind; he may say, "This looks good but the company won't accept it because . . ." or "This job is fair but it would be much better if you did it this way. . . ." This supervisor will recognize the importance of good workmanship for his client because he knows competence will help to offset his handicap.

Another special trait needed by our supervisor is the ability to see different ways to achieve the same work results. Ingenuity in developing methods of working and assistive devices for the by-passing of the client's handicap is a priceless quality in our production personnel.

The sheltered shop supervisor will need concepts and technics that do not apply to the foreman in industry. He will need to know how to deal with limitations in work tolerance and range of motion. He will need familiarity with the special terminologies and values of medicine, social work, guidance, and, in some cases, group work, because he will be a member of a team dominated by these professions.

The sheltered workshop's production supervisor also will need to use the skills of several industrial specialties, for he will be called on to pinch-hit for production engineering, plant layout, quality control, scheduling, and expediting personnel. In industry many of the smaller shops do not employ these specialists and a foreman in these shops must pinch-hit in the same way. In fact, given the preceding qualities, all that is now required of our supervisors is that they possess the skills of any good supervisor in a job shop!

A number of good books deal with the art and technics of supervision as applied to commerce and industry. They supply excellent tools for our purpose as well. Although no attempt will be made here to duplicate this work, this is a good time to mention C. A. Turner's *A Practical Manual of Effective Supervision.*[2] In his discussion of basic concepts, Turner lists 22 areas of supervisory responsibility, broken down under the headings: production, employee relations, and customer relations. All these responsibilities should apply to anyone supervising workers anywhere.

Before a supervisor can train his workers properly, he must have a clear picture of the operations to be taught. This is essential for determining the appropriate training method and sequence to use. Efficient production is largely dependent on adequate instruction. Therefore, the supervisor should plan specific job instruction carefully. Some basic principles of instruction are: 1) The instructor should encourage an attitude of patience and painstaking effort in the learner. 2) He should have the objectives of the lesson clearly in mind. 3) Each factor to be taught should be presented in a logical learning sequence, usually the sequence in which it occurs in the process although occasionally the easier steps can be taught first. 4) Quality specifications should be kept in mind at every step of the instruction to avoid developing substandard workmanship. 5) Efficient procedures should be stressed during instruction. Training is a tool for increasing production and improving quality.

Whether to emphasize speed or accuracy first in training is a moot question. When a fast or slow speed requires the same motions or when the chance of spoiling expensive materials is great, it might be advisable to start the new worker slowly and stress quality. Some operations, however, are quite different when done speedily or slowly; in such cases it is essential to teach the procedures at normal operating speeds. This is particularly true of some machine operations. For instance, in operating a power sewing machine on a long seam, the method of holding the fabric is somewhat different from that for sewing slowly or on short seams. When turning metals in a lathe the speed of operation will be dictated by the kind of metal being turned. The speed for turning brass differs from that for working steel or copper.

The production supervisor should consistently practice good teaching methods and seek ways of improving them. *Elements of Supervision*[3] recommends these methods: *First,* give an introductory description of the complete process, detailing hazards to be avoided, the value and nature of the equipment and product, and the use of special tools and gauges. Such an explanation will help the client learn the operation faster. *Second,* demonstrate once at normal production speed and then more slowly so the worker can see each step clearly. During this demonstration it is important that the worker's view of the operation be that he will have when doing the job himself. *Third,* let the client do the job himself as soon as he is familiar with all details. This initial attempt should be under the direct observation of the instructor. *Fourth,* correction by suggestion and demonstration should accompany initial trials as well as later work. *Fifth,* checking back on the client's work is essential both during

early trials and as he progresses. This will prevent the formation of bad work habits.

If the foregoing training procedures are important for industrial supervisors, they are essential in a sheltered workshop, where one of the more important phases of training is directed toward instilling good work habits. We should never lose sight of the role of good work habits in the development of our clients. Superior workmanship can help even the score when a client moves into a nonsheltered environment, where he must compete with workers without his limitations.

Sometimes we hear the statement, "If the student hasn't learned, the teacher hasn't taught." Occasionally, when under pressure or when working with people whose learning capacity is retarded, we may consider this judgment unjust. If we pause for a moment to remember a very basic educational concept, it may relieve our feelings. The concept says that the teacher must always start working with the student *where he is*. In other words, all instruction must be reduced to terms and factors that will have the appropriate meaning for each student. With some immature clients, however, the major problem is not learning but retention. When this is the case, very close supervision and frequent reinstruction is unavoidably necessary.

The final objective of any rehabilitation shop is the eventual competitive employment of its graduates. With this in view, contract requirments of a specified quality and quantity of production within a given period of time assume a new importance—they can realistically measure the appropriate level at which clients can successfully be moved from the shop to private employment. The rehabilitation client's employment handicap usually extends beyond his capacity to do the job. He may need special equipment, facilities, or working hours or other considerations ordinarily not required. Therefore, a rehabilitation client whose skill and productivity have been developed to equal those of the *average* worker in the same area is not yet in a position to compete on a par. If his skill and productivity equal that of the *better* workers in his area, his bargaining position is improved. The rehabilitation workshop therefore should not settle for the level of performance that will merely satisfy its customers. It should aim for the level that will insure the success of its graduates.

This appears to be the approach used by Abilities, Inc., of Albertson, N.Y. While it does not seek to graduate its employees out of its plant, Abilities, Inc., really demonstrates the excellent capacities of its seriously handicapped workers. It operates without subsidy, shows a good profit, and continues to grow at a healthy rate. S. P. Small,[4] a satisfied customer, praises Abilities, Inc., for consistently going beyond the prime contractor's ground rules which he describes as "the threefold ability to manufacture a quality product, on time, at a competitive price."

It is not unusual for the production supervisor in a shletered workshop to identify with his clients, becoming somewhat involved emotionally. Watching handicapped workers struggle with things that are relatively easy for the nonhandicapped does have a strong emotional appeal, and it is only natural for the supervisor to want to go easy rather than demand more and better production. Sometimes the need to apply production pressures to a handicapped work force makes one feel like Simon Legree. Being soft in this situation is as inadvisable as failing to pull a fractured limb straight before applying splints because the pull will be painful.

Any phase of rehabilitation is a tough job for the client. This is as true in the vocational phase as it is in physical medicine. The physical therapist who excuses his patient from exercise because it is difficult and painful may well be cheating him of realizing his full functioning potential. It is equally important for the work supervisor to use the pressures of production demands constructively, so he does not keep his client from his fullest work potential.

On occasion a supervisor may fear that correcting the worker or demanding more productivity will discourage and demoralize him. While it is true that some clients lack self-confidence and are so insecure that great care is required, the supervisor should not refrain from making the demands. Often the lack of self-confidence and a general insecurity are caused by the dependency engendered by hospital care or overprotective practices in the home. Before these clients can regain the self-confidence of independence, they must practice responding to gradually increasing demands for more and better work. Pressing for production with this type of client calls for considerable sensitivity on the part of the supervisor. Sometimes he should stress the progress already made before pointing out what more is needed. Sometimes he will want to set a series of easily attained immediate goals and thus lead the worker through a number of small steps to the desired level of performance.

We who work with the handicapped must never forget that, when we do not demand full participation and so fail to meet our contract commitments, the penalties we pay personally are but a fraction of the total cost. The major payment falls to our clients, who become less able workers with reduced earnings and employment opportunities. In the final analysis we do not rehabilitate the client. At best we can only help him do the job himself. When our demands are unrealistic we are hindering the client rather than being of help to him. The supervisor who is in industry also often finds that the imposing of production pressures and quality demands is a problem area.

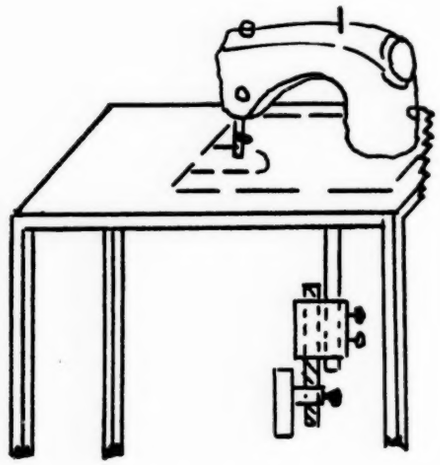
Modern supervision is much concerned about a constructive atmosphere on the job. In speaking of the atmosphere of approval, Mason Haire[5] describes it as the freedom to make mistakes. He points out that this does not mean tolerating low standards of work. It implies the recognition of the honest mistake that comes from someone trying something and failing to accomplish it. He says that it is quite possible to correct mistakes with an atmosphere of approval and to maintain a high quality of work performance in this atmosphere, while it is equally possible to have an atmosphere of disapproval with rather low standards of work.

Jigs and other assistive devices can often multiply an individual's productivity and earnings, but it is advisable not to become overenthusiastic and carry the provision of gadgets to unrealistic lengths. We must not further handicap our clients by building up a dependency on assistive devices that will prove awkward or expensive in the final industrial setting, even though they may be helpful in a sheltered or isolated environment. An example of this is training a one-handed person to type on an especially designed machine, although he is to be placed in the usual business office. A prospective employer would probably disapprove of this need for special equipment of no use to anyone else. A one-hand typewriter should certainly be used, however, if the person is to operate his own business or expects to type in his home only. An employer, however, would take a different view of an offset knee-press bar for a bar-tack operator who has lost function in his right leg. Such a bar can be attached by existing set screws that hold the usual straight bar on a standard machine. The operator can do the adaptation himself in a few minutes and it will not impose a hardship on another worker using the same machine.

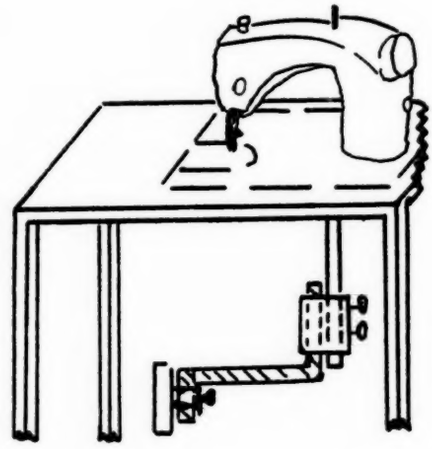
When the production supervisor evaluates a job for terminal workers, any assistive device to improve productivity or ease of operation should be provided. For instance, a one-handed worker over age 65 might well use a holding fixture for the packaging of small items in a sleeve-covered box as illustrated on the next page.

A double fixture of the type illustrated, if it would increase the productivity of workers with two able hands, should be used with those clients who may be moving on into the packaging industry as well.

Indication for individual work adaptations rests on still another consideration. Assistive devices may be needed to help a young client in need of habilitation in surmounting psychological blocks created by his greater dependency and feelings of being different. They may help demonstrate that he does have a capacity for work. The slow learner or mentally retarded client can sometimes be assisted to grow beyond his present level through some work adaptation that can be discarded later. Many retardates, unable to count, can be helped to do a job slowly but accurately. When 10 or 15 items are to be packaged, the appropriate number of spaces may be ruled off on the bench top and the retarded worker instructed to place an item in each space and then pack the complete set. After working the job this way for a time, some gain the ability to count and package the items accurately in the usual manner. Helpful work adaptations that can be discarded later are always indicated, as is any other technic that will further the individual's progress.



Standard knee press



Offset knee press for operation with left knee

Setting Up the Job

The production supervisor of a sheltered workshop works with a marginal labor force, and many of his workers have special needs to be given first consideration. Devising the most efficient production procedures possible is of prime importance. It is axiomatic that the less attention the supervisor must devote to the production process, once set up, the more freedom he has to concentrate on

his clients. So, the more automatic controls he can build into his processes, the better.

Methods and Controls

In developing methods it might be well to start by finding the most efficient method for "normal" workers. Sometimes this has already been done by the customer, but improvement of methods is a continuing process and the best possible may not have been yet found. When the customer has not developed the operational procedure but has provided sufficient materials for a good trial run, the supervisor should do a preliminary study of the operation, writing it down, step by step, and trying to eliminate all unessential work and materials handling. Once the trial run is started it should be observed closely to eliminate waste motions or handling not screened out by the preliminary study. This is also the time to study the possibilities for inserting automatic controls such as quality checks or automatic counts.

In testing the process developed or suggested by the customer, the following principles of motion economy are helpful.

1) The two hands should begin as well as complete their movements at the same time.

2) Both hands should not be idle at the same time.

3) Arm motions should be made in opposite and symmetrical directions and should be simultaneous.

4) Hand motions should be reduced to the least possible amount in performing the work satisfactorily.

5) Use momentum to assist the worker whenever possible.

6) Smooth, continuous motions are preferable to zig-zag or straight-line motions with sharp changes in direction.

7) Rhythm is essential to smooth, automatic performance; work should be arranged to permit easy natural rhythms whenever possible.

8) Tools and materials should be located to permit the best sequence of motions.

9) Hands should be relieved of all work that can be done more advantageously by jigs or fixtures or some foot-operated device.

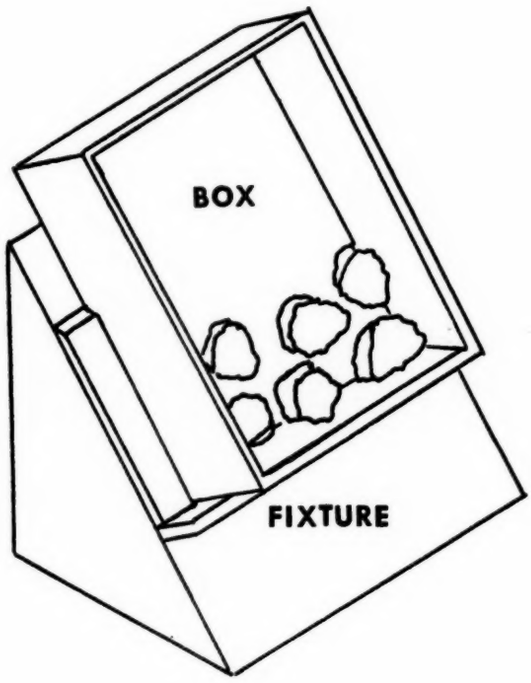
10) Two or more tools can sometimes be combined for more efficient use.

Another approach to work simplification is the testing of each step of each operation by using Kipling's helpers:

I keep six honest serving-men
(They taught me all I knew);
Their names are What and Why and When
And How and Where and Who.

Whatever method of analysis the production supervisor uses, all operations should be studied before and after they have been set up. To predict when or to whom an idea will occur that will multiply the productivity of any worker is impossible. For example, a large corporation had a job deburring balance wheels, and, although the initial method had been devised and used for some time in the burring department, a new worker on the job saw a possibility of making his work easier and safer, and, by changing the method, he multiplied his production by 10.

As originally set up, in the operation process the center hole of the wheel was fitted onto a tapered arbor while the lathe was at rest, the machine was started and one side of the wheel was polished with steel wool; the machine was then stopped and the piece removed and remounted so the other side could be polished. The machine was stopped again before the finished piece was removed. In an operation of this sort, there is a time lag between shutting off the power and the complete stopping of the spinning part. Since the balance wheel had a number of notches on its outer rim and, while spinning, had the effect of a saw, operators were frequently cut and lost time reporting for first aid. The daily quota on this operation was 400 pieces per operator. This process was changed so that the piece, held between two pads of steel wool, was placed on the arbor while it was in motion, both sides of the wheel were polished at the same time, and it was removed from the arbor without the machine's being stopped. The operators were no longer cut by touching moving parts they expected to be stationary, and the daily quota jumped to 4,000 pieces per operator.



The box extends above the back support of the fixture holding it in place while it is filled. The one-handed can slip the sleeve over the top part of the box before removing it from the fixture and closing it completely.

Developing job processes or setups for homework will add still other problems to those already solved for work to be done in the shop. The solutions for these problems will be highly individual, depending as they do on the physical facilities of each home and the capacities of each worker. Usually inprocess inspection will not be feasible and final inspection methods must be developed to cover all critical points. The training of homebound workers will need to be very thorough or spoilage may become a serious problem.

Once the supervisor has evolved a satisfactory operating process for the job, he should write up the job specifications, describing each operation in its proper sequence and including quality specifications, inspection methods and sequence, time study data, pay and billing rates, delivery schedule, and shipping instructions. For his convenience this information might be kept on job cards with the back of the card used for a running inventory of incoming materials, completed work, and outgoing shipments.

Before writing up inspection methods and sequence for the job card, the supervisor should review the operational process to determine where inspection will prevent spoilage or wasted labor on items already spoiled. Quality, so important in production, must never be left to chance. Methods of insuring it need to be determined, worked into the job process whenever possible, and written into the job specifications, so that adequate inspection becomes an automatic part of the production cycle. Whenever possible, quality specifications should be expressed in numbers, with acceptable tolerances specified. When this is not possible, samples of acceptable work should be kept available, with the margin of acceptability clearly indicated.

Selection of Workers

After a satisfactory method has been devised, it is essential to review the selection of workers. If a production line is to be used, the operation each individual will do must be chosen, deciding if he can perform it adequately so as not to cause a bottleneck to the flow of the line. If not, he might be aided to function more effectively by a change in procedure or use of a jig.

The industrial foreman, when selecting workers for specific jobs, normally chooses those with the aptitude, capacity, and skill to produce the most of an acceptable quality of work at the lowest cost. The workshop production supervisor has additional criteria, considerations of the individual client's vocational objectives and needs. Appropriate selection of workers for rehabilitation purposes cannot be governed solely by production needs and costs. More important controls are individual workers' needs. It is essential to assign the worker who needs to practice skills or gain productivity rather than to select one who will facilitate meeting the production deadline. While it is imperative to fulfill the production quota, the workshop's primary responsibility is to develop the handicapped individual's work potential. Additional workers may have to be assigned in order to get the work out.

Materials Flow

With new work set up properly, opportunity is afforded to predetermine materials flow, facilitating the storage of incoming materials for effective handling. Inefficient materials handling is a major source of waste in labor cost and one of the first areas studied when industrialists decide to cut costs.

A basic principle of efficient materials handling is the routing of materials so they are moved as little as possible, and in straight, consecutive steps to eliminate passage back and forth over the same ground. When payment of wages involves piecework rates or bonuses, the setup of the job and flow of materials should provide an automatic count for each operator's work whenever possible. When this automatic count is impossible on a production line, it sometimes helps to give the line raw materials in precounted lots or to remove completed work in job lots of a predetermined size. Whatever technics are used, it is essential to keep accurate track of each individual's output, or the advantages gained through the use of piecework pay are lost and no client's productivity can be accurately evaluated.

Shipments, as received, should be checked in to insure the receipt of specified quantities of correct items. When job specifications have been entered on a job card, the person receiving the shipment should store materials in accordance with the materials flow as indicated by the job process. All materials for each contract should be grouped together in the same storage area and the incoming materials itemized in the appropriate column on the back of the job card.

Except when inprocess quality controls are so rigid that defective work cannot possibly reach the shipping area, it is wise to make a final inspection as articles are packed. The thoroughness of this inspection will depend on the effectiveness of the inprocess inspection. Advantage should be taken of this last opportunity to insure an adequate quality of workmanship. As shipments are sent out, the data should be entered in the appropriate column on the back of the job card. When entries are made consistently, an approximate inventory can be done simply by checking the cards.

The shop doing some primary manufacturing will have buying problems, the severity of which will depend on the items produced. A shop that manufactures a line of items made up of a variety of parts will find that buying raw materials can become chaotic unless a workable procedure for buying has been established. When a wide variety of raw materials is used, it is imperative that a

sample of each item be collected at some central place and each accompanied by information essential for reordering. A simple method for handling this problem with small parts is to mount items on sample boards with the name and address of the supplier, supplier's item number, price, and usual quantity ordered clearly noted. Including a notation of the items for which the part is used may help if manufacturing is done on an "on order" basis. This would facilitate the reordering of parts on receipt of orders and prevent material shortages when the work is in process.

Delivering raw materials and picking up completed work from the homebound call for some special considerations. Deliveries of raw materials should go out in balanced lots so there are enough of all items to work the shipment off completely. When packing for delivery it is important to check the location of the home. In large cities the homeworker may live on the top floor of a tall walk-up building. Inappropriately packed materials can impose undue hardships on the person making the delivery. A final inspection of incoming homework will be mandatory unless the person who makes the pickup inspects the work before removing it from the home. When this is feasible, repacking will be eliminated and labor saved.

Record-keeping

Precise and accurate records can determine the welfare of any institution. The production supervisor in a sheltered workshop needs accurate records to meet the federal and state legal requirements. Production and business records are necessary for operating efficiency and to satisfy his customers' requests for information. The volume of papers and paper work can become overwhelming and must be organized as efficiently as possible, especially for the shop floor.

The supervisor needs to have basic personal information on his clients at his finger tips. A card can provide concise data regarding medically prescribed physical and psychological limitations, work tolerance, therapy appointments, vocational objectives, and rehabilitation goals. Without such data at hand the supervisor may misassign clients when under pressure so they miss valuable practice opportunities. In some cases this misassignment can actually result in placing clients in work detrimental to their welfare.

Most records in a production department should be on file cards or in permanent record books. An exception is the individual daily production record or work slip giving the date, client's name, identification of work, quantity issued, time worked, and pay rate on each job done. At the end of the day the information on these slips can be entered in the daily production book, which will provide a permanent production record for the department. The slips can then be turned over to the bookkeeper for the compiling of the payroll. Later, if desired, these slips may be filed in the case folders of the workers.

The daily production book should be organized so that each job or contract has its own section showing the daily amount of production and time worked by individual clients as well as totals for each day. A summary page in each section can be used to enter weekly or monthly totals on units of production, time worked, and number of workers used. It will provide basic data for the efficient compiling of periodic reports, enable the supervisor to quickly give up-to-date information to the contractors, and be invaluable for the scheduling of production. The daily production book will provide production figures for the running inventory on the backs of job cards. It will also enable the supervisor to trace the productivity of a particular client over a period of time and on a variety of jobs. It can provide the field representative with valuable clues for making fast estimates regarding the shop's productivity and available manpower when bidding on new jobs.

It is highly important that shipping records be readily available in chronological order and in permanent form. Shipping tickets can be obtained in books providing detachable tickets duplicating nondetachable copies that remain in the book. Customer billing can be done directly from the permanent copies in such a book, eliminating the possibility of lost or misplaced shipping memos.

A receiving book is also essential for the workshop. This could be a loose-leaf binder organized to hold incoming shipping tickets in chronological order by contracts. When incoming shipments are consistently entered in a receiving book, the supervisor, by comparing these entries with those in the shipping book, can arrive at a quick inventory of all materials in the shop.

The shop doing primary manufacturing that requires a miscellany of raw materials needs records in book form of materials purchased. An adequate stock book can expedite the purchasing of needed parts if it has information on the location of suppliers of particular materials and if it provides the price, item number, and any special data needed for ordering.

Other personal records the shop supervisor will need to fill out or provide for reference from time to time include evaluative forms or check lists giving information on the client's work adjustment, productivity, and special problems. The reading of case histories will give the supervisor a better understanding of his clients. Record needs for different purposes will vary but all records should be readily available, concise, and easily interpreted.

Meeting Contract Commitments

The importance of meeting all contract commitments goes beyond the ethical question of a shop fulfilling an obligation. Failure in this respect not only can lose

customers who may or may not be wanted but has more far-reaching results. Other sheltered shops in the area may find that a prospective customer is unwilling to deal with them because of an unhappy experience of this sort. An industrialist with no personal dealings with sheltered shops is sometimes unwilling to consider doing business because of a friend's experience with a poorly managed shop. This ill will in local industry can drastically reduce the employment opportunities of the graduates of sheltered shops. Satisfied customers are an important facet of the rehabilitation center's public relations, as they can influence the success of all vocational rehabilitation efforts in the community. Sheltered work organizations should give serious thought to helping their production staff to attain skill in handling customers.

We should remember that many of our clients have no recent working experience outside the shop and will need meaningful references in competing for a job. References from a shop without a good reputation industrially may hinder more than help. The industrial reputation of any shop is quite dependent on the quality of its workmanship and the consistency with which it meets its delivery dates.

Production Schedules

The meeting of contract commitments depends largely on the scheduling of production. The time study information on the job card, when evaluated in terms of the usual productivity of the workers assigned to do the job, will provide a sound basis for scheduling production. Worker productivity can be estimated by reviewing the daily production book. When scheduling a job to meet time commitments, it may be wise to include an additional time margin to offset emergencies when workers are absent or are removed from the job to help out on another under unexpected production pressure.

The production supervisor, when able to schedule all jobs sufficiently in advance, can prevent many of the rush periods and production emergencies that so often harass the production staff of sheltered workshops and job shops as well. Admittedly this is very difficult to do in a contract shop where the supervisor has limited control over the availability of raw materials. One approach to scheduling under this handicap is a plan to stockpile completed or partially completed work whenever possible and on as many contracts as possible. The limits imposed on stockpiling by lack of space for storage can sometimes be broadened by making deliveries ahead of schedule.

When planning the production schedule, each worker's program of other activities must be kept in mind and time for this added to the allowance for cushioning emergencies. It is always advisable to set definite production quotas for specified periods of time and to follow up to make sure these quotas are met.

The production supervisor also must co-ordinate his production plans with the rehabilitation plans for individuals and groups in other ways. The working experience is most helpful when it reinforces other corrective technics. When the shop is attached to a comprehensive rehabilitation center where functional occupational therapy and other therapies are provided, the person's work may be organized so as to serve as an extension of the therapy, sometimes providing prescribed exercise. If the supervisor intends to be as productive a team member as possible, he will keep informed of the current therapies of his clients and understand their functions.

If the shop has several departments or contracts are shared with other shops, the supervisor must help in co-ordination. Often others will be unfamiliar with his production methods. He needs to learn what the other shops produce within a given time before counting on their production in meeting his delivery dates. Some check on the quality of their work is essential in the beginning. It might be well in sending new work to other shops to do so on the basis of developing a stockpile, rather than to count on their production in meeting commitments. The same is true when work is sent to new homeworkers or to those who have never done a particular operation.

Controlling the production of a group of homeworkers presents many problems. The productivity of homeworkers trained in the shop will decrease when they start working at home and without the incentives provided by the group situation. It will therefore be necessary to develop their productivity to a level above that needed to earn their minimum hourly rates before terminating the training. Their craftsmanship should be developed to a point where minimum inspection can insure quality control, because when they work at home inprocess inspection will not usually be feasible.

Customer Relations

It is not unknown for customer demands on a shop to go beyond the original contract agreement. With the present trend toward rapidly changing work procedures, some demands may be legitimate, but others may not be justified. The person handling this kind of situation should have a detailed record of the agreement to help him deal with a potentially difficult problem.

When a customer requests a change in the process used for his work, it may mean a saving in labor costs and he may ask for an adjustment in price. If this happens, it is desirable to re-evaluate the work in line with the requested change. If the original pricing was done through an element time study, all that is necessary may be to deduct the labor charge for eliminated elements. On occasion a change in process may be an addition. If an element time study was done originally, timing of the new elements may be the only need. All such repricing should include a review of the total process, because the

change may so alter the operating rhythm of the job as to cancel out or magnify the time lost or gained. In any case, when changing the price of a job, any retraining required should be allowed for.

When a customer's demands are not justified, it is important for the supervisor to retain his sense of humor and not let his natural reaction to unfair demands trick him into a defensive attitude leaving him at a disadvantage. Great tact is advisable in handling unfair demands. Standing on our rights may be an empty victory if the customer is antagonized. Usually a copy of the contract confirmation and an honest statement of the shop's position can serve to win the customer's co-operation and prevent future misunderstandings.

Although most of us like to think we always meet all of our commitments, the fact remains that on occasion a customer will have a legitimate complaint. It is a common human failing to try to justify our errors, when an honest admission of the error and an offer to correct it are usually more acceptable. Still a shop supervisor working under pressure is apt to feel defensive and try to justify his failings, especially when he is in the wrong. An example of this is the supervisor of mentally retarded workers who was overheard using his clients' handicap as a justification for failing to meet quality specifications. The damage such an excuse could do to the total agency program is inestimable. There may be occasions when an admission of error and an offer to make amends will not satisfy the customer, but no possible occasion can justify the use of our client's handicap as an excuse for not meeting specifications.

Sometimes an emergency may make it impossible for a shop to meet its delivery date on a particular contract. When this happens it is imperative that the customer be notified at once so he can take whatever action possible to protect his own delivery schedule. In preventing situations of this kind it may be helpful if the workshop has an agreement with other sheltered programs for using their work force through sharing contracts or by the use of workers in their own shop during the emergency. If some part of the contract is to be processed in another shop the customer should be told of the arrangement and his consent obtained. When neither of these methods can be used and the customer must be told that the shop cannot provide the production he is expecting, it may still be possible to recommend another shop the customer may use in overcoming his production shortage. This co-operative attitude will help reduce the customer's annoyance at not receiving the production when it was promised him.

Good customer relations can be equated with good human relations. The skills involved are complex. Luckily the production supervisor has usually developed considerable skill in human relations through dealing with his clients. The customer, like the client, is human and the technics that work well with one will often be as effective with the other. When we make friends of our customers, we will find them very helpful in many of our problem areas. Our responsibilities are such that we should certainly welcome all the help we can get from this source, especially since it will enable us to do a better job.

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Review of the Month

Social Rehabilitation Of the Subnormal

by

Herbert C. Gunzburg

M.A., Ph.D. (Vienna), F.B.Ps.S.

Published in England by Bailliére, Tindall & Cox, Ltd., 7 & 8 Henrietta St., London, and distributed in the United States by Williams & Wilkins Co., Baltimore 2, Md. 1960. 263 p. illus., figs., charts. $6.50.

Reviewed by Joseph J. Parnicky, M.S., Ph.D.

About the Author . . .

Dr. Gunzburg, consultant psychologist and the director of psychological services, Monyhull Hospital, Birmingham, England, has been closely associated with the rehabilitation schemes described in the book under review, as he was the first education and training officer at Monyhull Hall Hospital, appointed in 1948. He has frequently contributed to the literature, writing on various aspects of mental defectives, their social adjustment, testing, and educational regimens.

About the Reviewer . . .

Since July, 1959, Dr. Parnicky has been superintendent of the Edward R. Johnstone Training and Research Center in Bordentown, N.J., a residential center for educable adolescents. A lecturer at Trenton State College and Rutgers University, he was formerly on the University's faculty. After training in sociology at Brown University (A.B., 1940), Dr. Parnicky did graduate work in psychiatric social work at Boston University (M.S., 1942). At New York University and Adelphi College (Ph.D., 1954), he studied clinical psychology. Dr. Parnicky worked in Army psychiatric clinics during World War II. He is the author of a number of publications, writing on rehabilitation, mental retardation, and institutional programs.

"IF ONLY SOMEONE WOULD WRITE a practical book; a book that discusses the everyday problems of those working directly with the retarded!" is an often expressed wish of institutional personnel and others in the field. Dr. Gunzburg's book is an answer to those seeking the *opus pragmaticus*.

For such readers the latter half of the book will be of prime interest, for it is here that the author deals with "schemes of work and therapeutics . . . [which] have actually been tried out in more than one hospital" *(p. xvi)* in programs designed for the subnormal late adolescents and young adults who show a potential for rehabilitation. In this section Dr. Gunzburg considers such topics as: "An Educational First-Aid Scheme"; "Pre-industrial Training in Institutions"; "Counselling the Delinquent and the Maladjusted"; "Discipline and Punishment"; "Relationship between the Sexes"; "Training for Leisure"; "Failure on Licence" (*i.e.*, on community placement). This sample of headings is evidence enough that the author is not fazed by difficult and controversial topics.

Dr. Gunzburg approaches rehabilitation of the subnormal individual as a psychologist with Viennese training and considerable experience, including a dozen years at Monyhull Hospital, Birmingham, England, where he is consultant psychologist. This hospital has been a center for much experimentation and re-evaluation of institutional programs for individuals who are subnormal.

Even though there are allusions to shillings and cricket clubs, the principles enunciated and issues raised in reference to programing for subnormal youth are certainly worth consideration by staffs everywhere. The author's governing philosophy is essentially pragmatic. He strongly advocates an integrated and graduated institutional program directed toward enabling the trainee academically, vocationally, and socially and one that utilizes the institution's capabilities on an around-the-clock basis.

The chapter on vocational training is a particularly good sample of how thoroughly Dr. Gunzburg develops the rationale for and detail of institutional training. In advocating the introduction of preindustrial training experiences for institutional residents, he supports his case with a realistic overview of what are suitable work opportunities for the increasing number of persons being placed in urban communities after institutionalization. He critically examines the existing institutional programs and concludes that "training through maintenance departments in institutions is very often not as satisfactory as it should be" *(p. 148)* in preparing a trainee for gainful employment in the community.

As prerequisite to a well-designed vocational program, the author stresses three basic considerations: "(*a*) what particular capacities are in need of training, (*b*) for what type of work they should be trained, and (*c*) what is the maximum efficiency that can be expected" *(p. 148-149)*. He does not leave it to the reader to implement these generalizations, as many an author is apt to do. Drawing on the Monyhull program, he illustrates by text, pictures, sample records, and case illustrations how various aspects of training can be purposefully devised to fulfill the objectives that are set by the aforementioned considerations.

Anyone intimately involved in institutional rehabilitation cannot but empathize with Dr. Gunzburg as he consciously strives to evolve a work-training program in the institution that simulates work conditions in an industrial operation, without losing sight of the special attention the subnormal requires because of his particular characteristics. In this regard he notes, "Whatever training is given the fact that it is adjusted to the subnormal's needs, makes it impossible to approximate conditions to the rough and tumble of the world, . . . where the dullard's difficulties are not understood and where consequently too much is asked of him" *(p. 212)*. Once again he does not stop short of grappling with this seemingly insoluble problem.

The author is convinced that much of the resolution of this situation can be met through greater involvement of the trainees. "Since the staff in an institution, because of their training and position, cannot provide the community atmosphere of ordinary life, the subnormals themselves must be formed into a community which, by being less tolerant and less knowledgeable, has much in common with real life" *(p. 212)*. In offering this prescription for reducing the debilitating effects of oversheltering aspects of institutionalization, Dr. Gunzburg is mindful that this is no panacea, as indicated in his comment, "We can by no means be sure that this graduated system of social adaptation leading to final discharge is really as effective in the individual case as might be thought" *(p. 226)*.

The reviewer found it unbelievable that Dr. Gunzburg considered the chapter "Special Institutional Training Aspects," in which the above ideas, among others, were presented, as being "of a less constructive nature than those preceding it" *(p. 225)*. In fact, this was among the most stimulating portions of the book and far from "destructive in its approach" *(p. 225)*.

Rather, the reviewer found himself questioning more of the material in the introductory chapters, where Dr. Gunzburg sets forth a series of definitions and a theoretical substructure for the integrated and graduated institutional program. Here the author from time to time lapses into sweeping generalizations without presenting substantially the bases from which they are derived. For example, in discussing psychological testing he categorically states that "all intelligence testing assumes that mental development ceases at adolescence" *(p. 64)*. Another, "a slight majority of people (nearly 60 per cent.) are considered to have I.Q.s below 100" *(p. 8)*. Such statements are particularly puzzling when one compares them with Dr. Gunzburg's contribution to the book *Mental Deficiency: The Changing Outlook*, edited by Ann M. Clarke and A. D. B. Clarke *(The Free Press, Glencoe, Ill., 1958)*. His chapter on "Psychological Assessment in Mental Deficiency" in the Clarke book is free of such questionable positions and is a much more solid statement of the clinical approaches and the difficulties they present.

The term *subnormality* as used in this publication deserves comment. Dr. Gunzburg holds that intelligent behavior is exhibited in three ways: as verbal intelligence, nonverbal intelligence, and social intelligence *(p. 21)*. He designates as subnormal any individual deficient in one or more of these three. This is in keeping with the 1957 report of the Royal Commission on the law relating to mental illness and mental deficiency. Such classification appears to make the category even more heterogeneous than that used previously and presents certain problems in clinical differentiation as summarized by Tizard in the Clarkes' volume (*op. cit.*, p. 3-20).

Furthermore the nomenclature is significantly at variance with the definition of mental deficiency developed by the American Association on Mental Deficiency (Heber, R.: *A manual on terminology and classification in mental* retardation," *Am. J. Mental Deficiency*, 65:4, Jan., 1961, *Deficiency*, 64:2, Sept., 1959; Heber, R.: "Modifications in the manual on terminology and classification in mental retardation," *Am. J. Mental Deficiency*, 65:4, Jan., 1961, p. 499-500). The nomenclature is generally at a tangent with the legal designation of mental deficiency drawn by state statutes. In reviewing the application of the program outlined by Dr. Gunzburg, one must keep in mind the type of population served by the British institutions he cites and that of the institutionalized within the United States.

As to the duration of rehabilitation envisioned by Dr. Gunzburg, the reviewer is somewhat perplexed. The author subscribes to the thesis, "the modern hospital tries to initiate adjustment to society's demands in the course of a few months where the old traditional 'colony' took years" *(p. xv)*. Yet, if one were to apply the range of program he details, it could easily stretch into years. Perhaps this reflects a differential in the advance of institutional programs in Britain and America. It seems as though institutions on these shores are still making progress when they convert from lifelong programs to those spanning but a few years. This may also reflect a difference in institutional populations of the two, as implied above.

In a number of places it appeared to the reviewer that the worth of the text would have been augmented, not just for the sophisticated reader, if footnotes with reference material had been included. Granting Dr. Gunzburg the right to write in a nontechnical style and to aspire to interest everyone, one might be more accepting of this if he had stayed true to his statement that "references have been omitted" *(p. viii)*. But for some reason he felt impelled to make a few exceptions to this self-imposed rule. Curiously these occur in the early pages and not again until the closing pages. If only he had yielded more often! He does give suggested readings at the end of most chapters. These are bound to be wanting for professional practitioners. For example, only a handful of journal articles bearing on the subjects covered are cited. Lest some be misled, it should be noted that Carmichael edited the revised version of *Manual of Child Psychology* in 1954 and not 1854 *(p. 238)*, and Sarason has replaced the 1949 version of *Psychological Problems in Mental Deficiency* with a second revision in 1959 *(p. 199)*.

Dr. Gunzburg's position on the role of various disciplines in the field is among the points that may stir some controversy. The psychologist appears, he declares, "because of his relevant training and comparative freedom from routine work, to be the most suitable person to be in charge of the more formal aspects of rehabilitation work" *(p. viii)*. Whether or not one accepts this conclusion and its justifications, certainly the author cannot be speaking of the American psychologist when he says that this practitioner "arrived in the hospital for subnormals only comparatively recently" *(p. viii)*.

Skipping into the middle of the book, one reads: "It requires so much expert knowledge and experience to use and interpret the results of intelligence and personality testing that these techniques are best left to the specialist. Educational assessment, however, is a different matter . . ." *(p. 90)*. Since the same chapter includes social as well as educational evaluations, readers may interpolate that specialists are likewise not needed for the social evaluation. In evaluations "limited to such knowledge as will be of immediate practical use" *(p. 91)* and as outlined in the records included, the author's position may be tenable. If this is a position regarding the expertness required for a comprehensive educational and social evaluation of an individual believed subnormal or deficient, it will be interesting to hear the reaction of educators and social workers. Before any heat is generated, it would be sound to investigate the difference in connotation of the word *specialist* here and abroad.

All in all, Dr. Gunzburg has succeeded in underscoring that "there is much room for questioning tradition and beliefs, and asking whether what has been useful and necessary in the past is still useful and necessary in the present, in view of our increased knowledge and more ambitious aims" *(p. 226)*. The reviewer knows of one institution where staff will be urged to study this book's content and to analyze its application in the light of ongoing experience locally and in the field.

Other Books Reviewed

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Action for Mental Health; Final Report . . . 1961

By: Joint Commission on Mental Illness and Health

1961. 338 p. figs., tabs. Basic Books, Inc., Publishers, 59 Fourth Ave., New York 3, N.Y. $6.75.

PRINCIPAL FINDINGS of the 5-year study commissioned by Congress, to analyze and evaluate the needs and resources of the mentally ill, served as the basis of broad recommendations to improve national mental health services. Progress can be made only through solution of manpower problems, provision of facilities, and availability of financial resources sufficient to achieve minimum standards of adequacy. Based on 10 monographs published by the Joint Commission on Mental Illness and Health, each dealing with a major aspect of the problem, and on independent studies and information provided by the National Institute of Mental Health and other organizations, this final report contains current knowledge on treatment, public attitudes toward mental illness, and mental health problems and the resources for their solution. Rehabilitation services are only beginning to be recognized as part of the comprehensive program needed to insure return of the mental patient to the community. Aftercare of released patients would hasten recovery.

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Cerebral Palsy in Childhood and Adolescence; A Medical, Psychological and Social Study

Edited by: **J. L. Henderson, M.D., F.R.C.P.E.**

1961. 403 p. figs., tabs. E. & S. Livingstone, Ltd., Edinburgh, Scotland. 35s ($6.30).

THIS VERY DETAILED REPORT of a comprehensive survey of cerebral palsy in the Eastern Hospital Region of Scotland, conducted by the University of St. Andrews' Department of Child Health for the Scottish Council for the Care of Spastics *(22 Corstorphine Rd., Edinburgh 12)*, contains descriptions of preplanning and organization of the survey and analysis of a wealth of data. Chapters are included on incidence, prevalence, and social class; medical, neurological, and orthopedic aspects; associated disabilities; psychological and social aspects; and etiology. Conclusions drawn from the study and recommendations for the improvement of treatment and services for the cerebral palsied are discussed. Subjects were 240 children under the age of 21, ascertained as having cerebral palsy. A prevalence rate of 2.04 per 1,000 in children of school age corresponds closely with the estimated prevalence in most of the more thorough investigations made in Great Britain. A chapter of special interest compares results of this survey with those made by Asher and Schonell (1950), Ingram's Edinburgh survey (1955), the Northern Ireland survey by Gordon, Scott-Pearson, and Corry (1949), Woods' Bristol survey (1957), and surveys conducted in Sweden (Herlitz and Redin, 1955) and Norway (Andersen, 1957).

666

Chronic Disease and Disability; A Basic Medical-Social Guide

By: **Georgia Travis**

1961. 295 p. University of California Press, Berkeley 4, Calif. $6.00.

THIS TEXTBOOK for social workers provides a summary of socially pertinent medical facts about chronic diseases of adults. The social implications emphasized are those that relate to matters of budget, environmental services, counseling, and work with other agencies and professions. Begun as a training aid for use with the Aid to Disabled program administered by the California State Department of Social Welfare, it contains authenticated medical information from accepted sources; technical terms are those most commonly used. Discussions of children's diseases, alcoholism, and suicide have been omitted. The book was planned so that each chapter stands by itself; diseases covered include rheumatoid arthritis, diabetes mellitus, tuberculosis, pulmonary diseases, progressive diseases of the nervous system, epilepsy, cerebral palsy, paraplegia and quadriplegia, cardiovascular and cerebrovascular diseases, and cancer.

Initial chapters discuss casework technics in relation to

For Your Leisure-Time, Professional Reading

IN HIS FIRST BOOK *A Man's Stature,* Hank Viscardi told the story of himself and of J.O.B.—Just One Break. In *Give Us the Tools* he told us the history of Abilities, Inc., founded by him at West Hempstead, Long Island. In the present book,

A Laughter in the Lonely Night

By: **Henry Viscardi, Jr.**

1961. 338 p. Paul S. Eriksson, Inc., 119 W. 57th St., New York 19, N.Y. $5.00.

Viscardi tells the stories of 15 men and women who work at Abilities, Inc. They are the executives, shop workers, and department heads performing jobs you would find in any manufacturing plant with 400 employees.

These persons came from Brooklyn, the Bronx, Ohio, California, and Alaska and also from England, Latvia, Austria, India, and Israel. All have different backgrounds and abilities, but all have one thing in common: Each is handicapped in some way. At Abilities, Inc., the fact that you are an amputee or are paraplegic, cerebral palsied, or blind is not equated to disability but to the abilities of a personnel director, assembly line worker, accountant, electronics expert, cost estimator, or packaging specialist. Ellen, Gale, Murray, and Alex—and the others about whom Viscardi writes—are extraordinary only in their spirit and courage, and no different from you and me in their desire to make their own living. With feeling and a sense of the dramatic, Viscardi tells of their tears and laughter in the face of prejudice, pain, and self-rejection, and also of their joy of work, camaraderie and new-found confidence at Abilities, Inc.

—The Editor

the adult chronically ill and the family, relations with physician and ancillary personnel, and the psychosomatic concept and its implications for public assistance. Useful features of the book are the short glossaries with each chapter, a subject index, and a 21-page section of references.

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The Integration of Physically Handicapped Children into Group Service Agencies

By: **Herbert Barish, Marie Louise Carl, Edward M. Foy, Cynthia Hallahan, Eva Lessy, Evalyn Quog,** and **Adele Rudich** (Submitted in partial fulfillment of the requirements for the degree of M.S. at the New York School of Social Work, Columbia University)

May, 1961. 79, xiii p. tabs. Mimeo. Looseleaf. (Available as long as limited supply lasts from Mr. Melvin Herman, New York Service for Orthopedically Handicapped, 853 Broadway, New York 3, N.Y.)

THE EVALUATION PROJECT undertaken in 1960 by 7 students from the New York School of Social Work, in conjunction with group work programs initiated by the New York Service for Orthopedically Handicapped, attempted to determine the success achieved in placing handicapped children in two types of programs—a day camp and after-school recreational programs. Positive and negative factors influencing successful integration were weighed; the findings, when analyzed, confirmed the belief that integration of handicapped children with the nonhandicapped could be successful. Physical limitations, in themselves, did not appear to lessen the child's satisfactions in the experience, except where no attempt was made to overcome the child's inability to participate in activities. Participation in such programs seemed more beneficial to children who had made adequate adjustment to their handicaps. Time of onset of disability and type of handicap were judged as factors influencing degree of adjustment. The experimental programs showed that group leaders need not have special training in working with the handicapped but should receive orientation on physical disabilities and degree of impairment of function. The recommendations and findings, useful for planning future programs of this nature, should reassure agencies considering integration of services for the handicapped.

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Mental Health in the United States; A Fifty-Year History

By: **Nina Ridenour,** Ph.D.

1961. 146 p. Published for the Commonwealth Fund by Harvard University Press, 79 Garden St., Cambridge 38, Mass. $3.50.

WHEN CLIFFORD BEERS called together a small group of people interested in organizing a state association for mental hygiene in May, 1908, he also planned a national society and dreamed of a network of state and local mental hygiene societies. Dr. Ridenour, who has been a part of many of the events related in this brief history of the early days of the movement, has not attempted to cover present-day developments. Current status and trends are summarized briefly in the final chapter. The impetus for social change and the means of accomplishing drastic reforms, the emergence of psychiatry as a science having "practical usefulness," the advent of guidance clinics for children, the treatment of mental illness throughout four world wars, and the growth of legal protection for the mentally ill are details of a story that has all the drama of fiction. Written to acquaint boards, staffs, volunteers, and members of mental health associations with the background of the movement, the book should also interest students in the medical, social, and behavioral sciences and, it is hoped, legislators and public officials responsible for allocation of funds and policy decisions relating to mental health.

669

Orthopaedics for Nurses

Edited by: **M. C. Wilkinson,** F.R.C.S., and **G. R. Fisk,** F.R.C.S.

1961. 363 p. illus., figs. Faber and Faber, 24 Russell Square, London, W.C.1, England. 37s 6d, net ($6.75).

THIS COMPREHENSIVE TEXT on orthopedic nursing, with chapters contributed by well-known authorities, was planned to present not only modern orthopedic theory and practice but also some of the older, basic technics. Nursing in spinal paraplegia is discussed by Dr. Ludwig Guttmann; Ruth E. M. Bowden, Professor of Anatomy, University of London, contributed the chapter on peripheral nerve injuries; Dr. Donal Brooks, one on anterior poliomyelitis, and Doreen Allen, the chapter on cerebral palsy (p. 291-310). General aspects of orthopedic care—such as open-air hospitals and treatment, the hospital school, use of splints, and operative technics, brief descriptions of common deformities, ward management, and the treatment of specific conditions (skeletal tuberculosis, osteomyelitis, arthritis, traumatic injuries of all types, amputations, and congenital deformities, to mention a few) are covered. The many illustrations of nursing and surgical technics add considerably to the value of the book, which should be useful to nurses and physical therapists.

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Proceedings of the Second Workshop on Dentistry for the Handicapped

Edited by: **Manuel M. Album, D.D.S.**

1961. 211 p. tabs. Paperbound. Published by the University of Pennsylvania School of Dentistry and available from Mrs. Mary W. Kolb, Postgraduate Office, 4001 Spruce St., Philadelphia 4, Pa. $7.50. (Checks should be made payable to Lester W. Burket, Trustee.)

FUNDAMENTAL CONCEPTS necessary for better understanding of dentistry for the handicapped patient and selected phases of treatment were covered in lectures presented during the morning sessions of the Second Workshop. Seminar groups, during the afternoon sessions, discussed and evaluated content of the lectures. The Proceedings contain papers and lectures, together with a summary of seminar discussions.

Contents: Public health services for the mentally retarded, D. A. Soricelli.—Association of current chromosomal studies with disease, William J. Mellman.—Oral lesions in mental retardation, Manuel M. Album.—Periodontal disease and dental caries in mongolism, M. Michael Cohen.—The dentist and the institutionalized mentally retarded patient, Leonard S. Hugunin.—Psychological approach to mental retardation, John R. Kleiser.—General anesthesia for dentistry in the mentally retarded child, M. Digby Leigh.—Newer drugs for dental use in mental retardation, Manuel M. Album.—Physiology of drugs and their application in mental retardation, Herbert Freed. — Seminar discussions. — Seminar reports.

For a brief review of the proceedings of the First Workshop on Dentistry for the Handicapped, see *Rehab. Lit.,* June, 1959, #464.

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Psychological Aspects of Rehabilitation; Follow-Up Studies

By: **Louis E. Masterman**

1961. 155 p. figs., tabs. Mimeo. Spiral binding. *(Publ. no. 132)* Community Studies, Inc., 724 Railway Exchange Building, Kansas City 6, Kan.

THE FIRST REPORT on a series of studies by Community Studies of Kansas City, concerned with psychological aspects of disability, was issued in 1958 and presented an evaluation of the psychological status of a group of patients prior to their entering a comprehensive rehabilitation program (see *Rehab. Lit.,* Dec., 1958, #1363). The current follow-up of the original patients attempted to evaluate psychological benefits that accrue as by-products to successful rehabilitation, both during the treatment program and during a one-year follow-up. The report also throws some light on the question of whether or not the psychological benefits of rehabilitation are lasting, persisting after treatment and service programs are terminated. The individual's over-all adjustment was the main consideration in determining whether he had improved, shown no change, or regressed. Among adults in the study, factors interfering with rehabilitation appeared to be anxiety, fantasy, hostility, lack of self-confidence, psychosomatic complaints, and thinking inefficiency. Four case histories and evaluations made by rehabilitation team members are used to illustrate successful and unsuccessful results, often predicted in the original rehabilitation prognosis. The appendix contains definitions and explanations of characteristics expected to interfere with rehabilitation.

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Public School Speech and Hearing Services; A Special Report . . .

Prepared by: **Research Committee, American Speech and Hearing Association**

1961. x, 163 p. figs., tabs., forms. Paperbound. *(J. Speech and Hear. Disorders, Monograph Suppl. 8, June, 1961)*

AUTHORITATIVE INFORMATION on current practices in speech pathology and audiology in the nation's school systems and the administrative and technical problems of those concerned with speech and hearing reeducation in public schools is provided in this research report of a survey conducted by the American Speech and Hearing Association. Project director was M. D. Steer, Purdue University. A major objective of the survey was to identify unresolved problems, evaluate their significance, and specify which could be solved through modern research methods. The study was supported by a grant from the U.S. Office of Education.

Contents: Introduction: The problem and the project procedure, Betty Ann Wilson.—The public school clinician; professional definition and relationships, Helen Knight (and others).—Supervision of speech and hearing programs, Martha E. Black (and others).—Program organization and management, Dale S. Bingham (and others).—Clinical practice: Diagnosis and measurement, Vivian I. Roe (and others); Remedial procedures, Myfanwy E. Chapman (and others).—Speech improvement, Geraldine Garrison (and others).—Professional standards and training, Ruth Beckey Irwin (and others).—Recruitment for careers in speech pathology and audiology, Gretchen M. Phair (and others).—Research: Current status and needs, Wilbert L. Pronovost (and others).—Summary: New horizons, Theodore D. Hanley and Frederic L. Darley.—Appendixes (forms used in survey).

Single copies of the monograph available from Kenneth O. Johnson, Business Manager of Publications, American Speech and Hearing Assn., 1001 Connecticut Ave., N.W., Washington, D.C., at $1.90 a copy.

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Some Facts and Recommendations Concerning Recreation Services to Clients of Representative Types of Sheltered Workshop . . . Final Report of the Two-Year Project, June 15, 1959-June 30, 1961

By: **Consulting Service on Recreation for the Ill and Handicapped, National Recreation Association**

1961. v, 82, (12) p. tabs. Mimeo. Looseleaf. National Recreation Assn., 8 W. Eighth St., New York 11, N.Y.

TO AID WORKSHOPS in defining and delimiting their responsibilities in meeting recreational needs of their clients, the Consulting Service planned and conducted a study intended to answer questions on kinds of recreation services needed by sheltered workshop clients, how the client's disorder affects needs for such service, and how his socioeconomic situation influences types of services required. Directors and staff and 240 clients of 12 selected workshops were interviewed, as well as staffs of 92 agencies providing services in the communities. Conclusions and recommendations, based on the study, and suggestions for further research are included. A 13-page bibliography concludes the report. The project was supported by a grant from the U.S. Office of Vocational Rehabilitation.

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Speech and Hearing Problems; A Guide for Teachers and Parents

By: **Charles E. Palmer,** Ph.D.

1961. 137 p. illus., figs. Charles C Thomas, Publisher, 301-327 E. Lawrence Ave., Springfield, Ill. $5.50.

PLANNED AS A "FIRST-AID MANUAL" for parents and teachers concerned with speech and hearing problems of children, this book provides answers to questions most frequently asked, explains what may be done when professional therapists are not available, and suggests how parents and teachers may co-operate with professional personnel in the child's rehabilitation. Many therapists have noted that the greatest stumbling block in the child's acquisition of speech is the teaching method used by parents. Dr. Palmer counsels parents on speech and voice problems, difficulties of the child with partial hearing loss or deafness, and ways of helping the child to overcome his handicap. The informal, conversational style of his writing is well suited for his purpose; professionally reliable information is offered in language the lay public can understand. Parents of children with speech and hearing handicaps should have the book called to their attention.

Recent Reprints from Rehabilitation Literature

Described below are two of the latest reprints of articles from *Rehabilitation Literature* that may be ordered in quantity. Write for a complete list of reprints and for special prices for quantity orders.

Reprint DR-28

Significance of Public Attitudes in the Rehabilitation of the Disabled. By G. Allan Roeher, Ph.D., co-ordinator of rehabilitation for the province of Saskatchewan, Canada. (*Reprinted from March 1961 issue*) 25¢ a copy.

The formation of social attitudes, as reflected by present concepts in social psychology and sociology, is reviewed. Dr. Roeher discusses the effect of negative attitudes (prejudices) on the disabled and on rehabilitation programing. How attitudes may be favorably modified, and the responsibility of rehabilitation workers and agencies to effect these changes, are also discussed by the author in some detail.

Reprint DR-29

A Report on the Epilepsy Problem. By George N. Wright, Ph.D., national program director of the National Epilepsy League, Chicago. (*Reprinted from July 1961 issue*) 25¢ a copy.

The author wrote this article to clarify facts about epilepsy that make it a medical, psychological, and social problem. He has reviewed the prevalence of epilepsy in the United States, the causes and types of epilepsy, and its diagnosis and control. The author explains how public misconceptions affect the person with epilepsy in his ability to live a normal life.

Journal articles, chapters of books, research reports, and other current publications have been selected for digest in this section because of their significance and possible interest to readers in the various professional disciplines. Authors' and publishers' addresses are given when available for the convenience of the reader should he desire to obtain the complete article or publication. The editor will be most receptive to suggestions as to new publications warranting this special attention in Digests of the Month.

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Spastic and Cerebral Palsy Squint Problems

By: **Hobart A. Lerner**, M.D. *(332 Park Ave., Rochester, N.Y.)*

In: *Am. Orthoptic J.* 1961. 11:72-75.

STRABISMUS IS FREQUENTLY encountered in routine ocular examination of cerebral palsied children. In my series of 350 patients, it was seen in 15 percent, 29 percent of whom had esotropia [one eye fixes upon an object and the other deviates inward]. The incidence of strabismus was lower than in other series reported in the literature, perhaps due to the types of cerebral palsy found in the series. Sixty percent or more of spastics have strabismus, while athetoids and choreas have it less often.

Subnormal vision also occurs in 10 to 25 percent of a cerebral palsied group, depending on the series, high refractive errors are common, and optic atrophy is seen in 2 to 3 percent. It is difficult to test for visual field defects, but they are also found.

In examining the eyes of a child 1 to 3 years of age, an objective examination is stressed and the doctor's ability to observe is relied on. Our patients of course are often older. Many are mentally retarded—in over 50 percent the IQ is less than 70. In about half, speech defect interferes with examination. Spasticity, rigidity, choreiform and athetoid writhing movements, poor posture, and inability to hold the head up add to a below standard examination, filled with inaccuracies. Mental sluggishness keeps the child from understanding what is wanted and poor posture and motor difficulties lower co-operation. In about 32 percent of patients visual acuity can somehow be tested. The experience of the ophthalmologist in handling the patients is a deciding factor. A glimmer or sudden lighting of the eye indicates recognition of a letter or figure during vision testing. A grunt or incomprehensible sound means the child will co-operate and knows he is to look at the muscle light.

Good determination of visual acuity is not possible in most cases. Observation must determine whether the child can fix with either eye and if he has reasonably equal vision. Ocular rotations and versions are studied and convergence tested. In most, if not all cases, a reasonably accurate prism cover test can be done if the child can be interested. A refraction is done under cycloplegia [paralysis of ciliary muscle of the eye]. Care and accuracy are imperative in retinoscopy, since in most cerebral palsied patients the lens prescription depends entirely on findings. Older children and those with less severe brain involvement can co-operate better, but they are a small percentage of those seen. Although high refractive errors, including high astigmatic errors, are often found, a squint does not often respond to their correction. The percentage of accommodative squints is rather low.

A fairly large number of the children, both strabismic and nonstrabismic, have a monocular amblyopia [dimness of vision in one eye]. Treating this is difficult, for in the presence of so many disorders occlusion is an added burden. Usually an attempt is first made, with cerebral palsied children with strabismus, to prescribe a suitable lens correction if needed. If feasible, I try to improve the visual status of an amblyopic eye by carefully observed occlusion. Muscle studies are done to obtain a good measurement of the deviation. Surgery can improve ocular alignment and position if the child's mental level and status warrant it. Mental level is considered because of economic factors, often state aid being required. Many children also need orthopedic surgery to attain self-locomotion. Ocular surgery is warranted if co-ordination will improve and the child is intelligent enough to take advantage of it instead of being institutionalized.

In these cases, surgery on ocular muscles must be done with judgment and restraint, for results are not as predictable as in a normal child with strabismus. In general, a little surgery on a few ocular muscles at a time is successful in cerebral palsy while bold attack on several muscles results in overcorrection. This applies much more in esotropia than in exotropia [one eye fixes on an object, the other deviates outward]. An esotropia of 45 to 50 diopters, which in a normal child may require a bilateral recession of the internal recti of 4 to 5 mm., might, treated the same way in a cerebral palsied child result in an exotropia of 30 to 50 diopters.

In most cerebral palsied children orthoptic therapy is not required. Training them to co-ordinate their limbs in even a basic, grossly functional manner is a task for the physiotherapist and occupational therapist, and, in most, fine ocular co-ordination and fusion is impossible. Physical and mental deficiency usually cannot be overcome enough to achieve orthoptic ocular rehabilitation.

With those with minimal involvement with cerebral palsy, orthoptic therapy to overcome a squint is prescribed

when indicated; the results are comparable to those in children without cerebral palsy. Some cases are borderline. In isolated cases children with more than minimal involvement with cerebral palsy respond to orthoptic treatment. The ophthalmologist must, like other specialists treating the cerebral palsied, be satisfied in most cases with a limited degree of improvement achieved only after persistence and effort.

American Orthoptic Journal is published annually by the American Academy of Ophthalmology and Otolaryngology, 15 Second St., S.W., Rochester, Minn.

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Meeting the Feeding Problems in Nursing Homes

By: **Emma Ludwig, R.N.** *(Consultant, Chronic Illness and Geriatrics, Cleveland Division of Health, Cleveland, Ohio)*

In: *J. Am. Dietet. Assn.* July, 1961. 39:1:43-44.

WITH THE GREAT EMPHASIS on rehabilitation today, we must be concerned with the total picture of nutrition in nursing homes. In addition to menu planning, purchasing, storage, equipment, and sanitation in the kitchen, the rehabilitation factors are more important in the program than is evident. A closer union between the nursing and dietary departments will utilize technics that are being practiced on only a small scale.

Many homes have nonprofessional staffs with little chance to follow rehabilitation activities at mealtime. A dietitian can suggest ways to teach the staff procedures that will benefit the patient achieving independence. The dietitian needs more concentrated time in the dining area to do this.

With patients such as those with cerebral palsy, positioning is important in teaching self-help technics. Chewing and swallowing procedures will be improved and choking reduced if the trunk is tilted slightly forward, with the chin down, the buttocks set well back in the seat, and, if needed, the elbow stabilized with an arm rest.

Cerebral palsied patients can articulate better because of exercise offered by certain types of food. A normal diet should be preferred to mashed and ground foods. Chewing with the lips closed and drinking through a straw are good muscular exercises, helpful in speech practice. Drooling is controlled and the patient is more socially acceptable.

Some patients, depending on muscle involvement, are able to eat with the aid of only a leather cuff to hold the fork or spoon. Many are helped by a "spork," a combination fork and spoon. A swivel spoon should have a lock to keep the bowl from tipping too far; a child's size is usually too small for adults. Getting food onto a spoon is easier with an attachable metal plate-rim. A quadriplegic having the use of the opposite hand is helped by a food pusher properly angled.

In most homes the attitude is that it is much easier to feed the patient quickly than to teach the use of aids. The cook and other personnel are anxious to get a meal served, over with, and dishes washed, so that other activities can take place. Although most handicapped patients with feeding problems must have more time to eat, time spent training the patient in self-feeding will save untold staff time later and will make the resident happier and more independent.

Nursing homes inherit severe cases of bedsores. Good nutrition and excellent nursing care can do much for such patients after admission to a high-standard nursing home. I saw an aged ex-teacher enter one with an emaciated body and large decubitus ulcers on both hips, coccyx, and heels. Death was said imminent. For several weeks she had a liquid diet supplemented with minerals and vitamins and intensive nursing care. The physician then prescribed added foods ad libitum. Cooked fresh liver and kidneys, blenderized and mixed with brown rice and curry powder, was added to the diet. After 2 years, although still bedfast, the patient is much better, her bedsores are healed, and her memory is returning.

It is effective to group mentally regressive patients who have become untidy in eating habits into one area at small tables under supervision, sometimes by a mentally alert patient who loves such service.

In the senile (those with abnormal mental aging), mental confusion, varying stages of abnormal forgetfulness, paranoid attitudes toward others, aggressiveness, and agitation present a care problem wherever they live. One factor predominates—the food problem. The senile are generally admitted to a nursing home malnourished, some having lived alone and on bread and tea or coffee for indefinite periods. They cause the nursing home operator difficulty, telling visitors of being starved or having food withheld by the operator. After a time in the home, it is a thrill to see the improvement. Many factors—social, spiritual, emotional, and physical—produce it. Conditions formerly considered irreversible respond to therapy.

The Journal of the American Dietetic Association is published monthly by the American Dietetic Association at Mount Morris, Ill.; annual subscription rates: $8 in advance in the United States, Canada, and countries of the Postal Union; all others $9; undergraduate students and dietetic interns in approved internships $4.

Abstracts of Current Literature

This abstracting section, together with other numbered references indexed in this issue, serves as a supplement to the reference book Rehabilitation Literature 1950-1955, *compiled by Graham and Mullen and published in 1956 by the Blakiston Division of McGraw-Hill Book Company, New York. An author index will be found on the last page of the issue.*

AMPUTATION

677. California. University. Biomechanics Laboratory *(463 U.C. Hosp. Bldg., Univ. of California Med. Center, Third and Parnassus Aves., San Francisco 22, Calif.)*

Stump hygiene, by S. William Levy and Gilbert H. Barnes; illustrated by Thomas D. Harris. San Francisco, Univ. of California, c1961. 16 p. illus.

A pamphlet for amputees, offering basic rules for care of the stump. Although illustrations are of lower extremity amputations, rules are equally applicable to arm amputations. Brief text and illustrations describe the daily routine of skin care and care of the prosthesis socket, stump sock, and elastic bandages. Common skin disorders of the stump are discussed, with bandaging technics for above-knee and below-knee stump shown. The booklet is an outgrowth of a study of amputee problems supported by grants from the National Institutes of Health and U.S. Office of Vocational Rehabilitation, and is distributed by the Biomechanics Laboratory.

AMPUTATION—EQUIPMENT

678. Anderson, Miles H. *(Prosthetic Education Dept., Univ. of California Med. Center, Los Angeles 24, Calif.)*

Compensation for contracture deformity in an improved socket design for above-knee prostheses, by Miles H. Anderson, John J. Bray, and Charles O. Bechtol. *Arch. Phys. Med. and Rehab.* July, 1961. 42:7:485-491.

Analysis of records of above-knee amputees fitted with 301 quadrilateral suction-socket prostheses showed about 50% suffered from edema in the distal portion of the stump and from gait problems and excessive anterior pelvic rotation due to uncompensated abduction and flexion contractures, respectively. Research in developing methods of measurement of contractures and in designing a socket to compensate for contractures is described. Technics have been used in fitting 60 above-knee prostheses since September, 1959; follow-up examinations indicate edema is no longer a problem in patients so fitted. Definite improvements in walking have also been achieved.

679. California. University. School of Medicine. Department of Surgery-Orthopedics

(Prosthetics Education Program at. . . .) *Orthopedic & Prosthetic Appliance J.* June, 1961. 15:2:123-177.

This issue of the *Journal,* dedicated to the University of California at Los Angeles, the first to offer courses in prosthetics and orthotics in this country, contains articles contributed by University staff specialists.

Contents: Professional education; a nine-year report, Miles H. Anderson.—New UCLA Rehabilitation Center to feature multi-disciplinary approach, Ralph E. Worden. —Efficiency in technical teaching, Cameron B. Hall.—A half-century of progress; editorial, Raymond E. Sollars. —The goals of child prosthetics research, Milo B. Brooks. —Developmental factors in infant upper extremity prosthesis fitting, Julie Werner Shaperman, Milo B. Brooks, and Harry E. Campbell.—New developments in lower extremity prostheses for children, Harry Campbell, Betty Kitabayashi, and Carl Sumida.—Use of community resources in the continuing prosthetic care of the child amputee, Wilma Gurney and Jeannine F. Dennis.—Developmental research in a private facility, Joseph E. Traub.—Evaluation of control problems in externally powered arm prostheses, Hilde Groth and John Lyman.

Articles contain information on the objectives, educational program, clinical training, and research conducted at the University, the development of prostheses for child amputees, and the value of community services for continued care of the child amputee.

The *Journal* plans a similar issue at a later date, with articles contributed by Northwestern University's Prosthetics Staff. (See *Rehab. Lit.,* Nov., 1960, #799, for issue on New York University.)

AMPUTATION (CONGENITAL)

680. Kruger, Leon M. *(516 Carew St., Springfield 4, Mass.)*

Amputation and prosthesis as definitive treatment in congenital absence of the fibula, by Leon M. Kruger and Richard D. Talbott. *J. Bone and Joint Surg.* July, 1961. 43-A:5:625-642, 699.

Case records of 62 instances of congenital absence of the fibula in 48 patients at Shriners' Hospital for Crippled Children, Springfield, Mass., since 1925 are reviewed; the trend since 1950 is toward a more radical approach to the problem, by amputation and fitting of a prosthesis Discussed are etiology, comparative results of past and present treatment, foot deformity, psychological aspects of leg-length discrepancy, economic considerations, and results in patients undergoing amputation. End-bearing stumps are recommended for both boys and girls; early amputation and fitting of a prosthesis are advisable. The paper, presented at the annual meeting of the American Academy of Orthopaedic Surgeons in 1961, includes illustrations, 8 case histories, and discussion by Dr. Charles H. Frantz, Michigan Crippled Children Commission's Area Amputee Program.

ARTHRITIS—PROGRAMS

681. Robinson, H. S. *(Canadian Arthritis and Rheumatism Soc., British Columbia Div., 900 W. 27th Ave., Vancouver 9, B.C.)*

Rehabilitation of aged with rheumatoid arthritis. *Geriatrics.* Sept., 1960. 15:637-643.

A well-rounded program to meet the needs of arthritic patients, especially those over age 64, is discussed; major emphasis is on needed rehabilitation services in outpatient facilities and in the home, although rehabilitation should

be available in acute, chronic, and convalescent hospitals. Successful rehabilitation depends upon motivation, follow-up and supervision, use of self-help devices, and availability of funds to provide for needs of the impoverished. Extent of rehabilitation will also depend on presence of concurrent illness, extent of physical deformity, and recognition of residual physical capacity. Facilities available for use through the Canadian Arthritis and Rheumatism Society's British Columbia Division are briefly discussed.

AUDIOMETRIC TESTS

682. Eagles, Eldon L.

A study of hearing in children: I. Objectives and preliminary findings, by Eldon L. Eagles and Samuel M. Wishik; II. Acoustic environment and audiometer performance, by Eldon L. Eagles and Leo G. Doerfler. *Trans.,* Am. Acad. Ophthalmol. and Otolaryngol. May-June, 1961. 65:3:261-296.

With support from the National Institute of Neurological Diseases and Blindness and U.S. Children's Bureau, the Subcommittee on Hearing in Children, operating under the Academy's Committee on Conservation of Hearing, developed pilot studies to obtain normative data on hearing in children. Methods and technics for the Subcommittee's national studies have been developed. Studies were conducted in Pittsburgh public schools with the cooperation of the University of Pittsburgh and in Baltimore with the aid of Johns Hopkins University. The 2 papers present various aspects of study methods and results, with preliminary findings from the Pittsburgh study. Planned for at least a 5-year period, testing has been conducted with children ranging in age from 3 to 17 years, as a supplement to existing school health programs. Experiences with audiometer calibration and performance, summarized in Part I, are described in detail in Part II, which is reprinted from *J. Speech and Hear. Research,* June, 1961 (4:2:149-163), with minor changes.

BLIND—EMPLOYMENT

683. U.S. Office of Vocational Rehabilitation

Instructional guide for use in vocational schools providing training for blind persons, by J. Hiram Chappell; revised ed. Washington, D.C., Govt. Print. Off., 1960. 49 p. illus. *(Rehab. Serv. ser. no. 110, rev. 1960)*

Methods are for instructors in vocational schools to use in training the blind to handle tools and equipment, to observe safety precautions on the job, and to develop work tolerance and ability to orient and adjust to a work situation. Rehabilitation counselors can use the information in interpreting needs of the blind person to the instructor and in their joint assessment of the trainee's needed instruction. The pamphlet covers procedures of the 4-step pattern of training in use of tools or power equipment and activities for shop practice in both wood and metal shops. Tools needed, materials required, and adaptations of methods for each activity are discussed. The last 2 sections list examples of jobs in production and service industries not requiring sight, and describe and illustrate special tools useful to the blind. Vocational instructors in residential schools for the blind, public schools accepting blind students, and rehabilitation centers with blind clients will find the information up to date and helpful.

Copies available from the U.S. Office of Vocational Rehabilitation, Washington 25, D.C.

BRACES

684. Granger, Carl V., Jr. *(Dept. of Phys. Med., Letterman Gen. Hosp., San Francisco, Calif.)*

The adjustable knee splint. *Phys. Therapy Rev.* July, 1961. 41:7:516-519.

Design and dimensions of a knee splint for use in early training in standing balance and ambulation are illustrated and described. Used successfully in patients with paresis at the knee, secondary to a variety of neurologic disorders, the splint provides 1 point of pressure at the knee and 2 points of counterpressure—at upper thigh and at the heel (through the shoe). Caution should be exercised, however, when hyperextension is present. The splint can be readily adapted for turn-buckle traction to help stretch knee flexion contracture; the Hack convalescent boot should be worn in such instances. Advantages of temporary bracing in meeting immediate needs of patients are discussed.

CEREBRAL PALSY

See 675; 711; 722.

CEREBRAL PALSY—DIAGNOSIS

685. Wigglesworth, Robert *(7 Cranford Hall, Kettering, Northants., Eng.)*

Minimal cerebral palsy. *Cerebral Palsy Bul.* 1961. 3:3:293-295. (A letter to the editor)

The concept of "minimal cerebral palsy" is defined in the hope that family doctors, school physicians, psychologists, surgeons, ophthalmologists, and pediatric psychiatrists will recognize the concept's value in early diagnosis. Failure to recognize the child with a minimal degree of accepted signs of cerebral palsy may result in mishandling by parents, teachers, and the community. Simple physical therapy, given early, can help overcome "awkwardness," educational problems, and behavior problems many such children exhibit. The letter is based on Dr. Wigglesworth's experience in pediatric outpatient clinics and in follow-up of all premature babies born in hospitals in North Northamptonshire.

CEREBRAL PALSY—ETIOLOGY

686. Ingram, T. T. S. *(Dept. of Child Life and Health, Univ. of Edinburgh, Edinburgh, Scot.)*

The reproductive histories of mothers of patients suffering from congenital diplegia, by T. T. S. Ingram and Elspeth M. Russell. *Arch. Diseases in Childhood.* Feb., 1961. 36:185:34-41.

An investigation of 278 mothers of diplegic patients in Edinburgh provides some evidence supporting the theory that underlying abnormalities of the reproductive process may be responsible both for disorders of pregnancy, labor, and delivery and for the production of abnormal offspring. An analysis of data on social class of fathers, birth rank of patients, maternal age at marriage and birth of patients, maternal health and menstrual history, birth rates of mothers of diplegic children,

spacing of pregnancies, and contraceptive practices is included. A brief review of the literature is made.

CEREBRAL PALSY—RECORDS

687. Robb, Preston *(1610 Pine Ave. West, Montreal 25, P.Q., Can.)*

An introduction to the diagnosis of cerebral palsy and the use of a punch card record. *Canad. Med. Assn. J.* Mar. 25, 1961. 84:651-657.

The term cerebral palsy does not constitute a diagnosis but is used to indicate a multitude of conditions in children arising from abnormalities in the motor systems of the brain. Dr. Robb discusses briefly roles of medical and ancillary personnel on the treatment team, anatomy of the brain, and possible etiological factors in cerebral palsy. He gives a simple classification scheme used at Montreal Children's Hospital that differentiates by type of cerebral palsy, site of involvement, and degree of severity. Described and illustrated is a punch card to provide uniform indexing on cerebral palsy throughout Canada. Although the whole history cannot be recorded, the card is an aid in record keeping and useful in follow-up. Samples of the card may be obtained from the Canadian Council for Crippled Children and Adults, 31 Alexander St., Toronto 5, Ont., Canada.

CEREBRAL PALSY—SPEECH CORRECTION

688. Ohlsson-Edlund, Elly *(Eugenia Home, Stockholm, Swed.)*

Phoniatric treatment of children with cerebral palsy. *Cerebral Palsy Bul.* 1961. 3:3:222-226.

When admitted to Eugenia Home, a boarding school for children with serious motor handicaps and relatively normal intelligence, those with speech difficulties are referred to the therapist for special speech and hearing examinations. Technics used in treatment of speech disorders are discussed; results of therapy in 50 cerebral palsied children (31 boys, 19 girls), ranging in age from 3 to 18 years, are tabulated. Preschool children receive therapy adapted to their ages. Results indicate speech therapy for cerebral palsied children has an important place in their care and should be continued over a long period, to obtain maximum results.

CEREBRAL PALSY—SURVEYS—GREAT BRITAIN

See 665.

CHILDREN (DEPENDENT)

689. International Union for Child Welfare

Inter-country adoption. *Internatl. Child Welfare Rev.* 1961. 15:1:1-68.

Two main chapters from the report of the European Seminar on Inter-Country Adoption, held at Leysin, Switzerland, May, 1960, are reproduced here; they cover 12 fundamental principles to be followed in adoption, plus a guide to the application of casework principles in determining placement. Considerations in adoptions of physically or mentally handicapped children and on qualifications of adoptive parents are discussed on pages 14, 41, and 46. It is recommended that such children be placed within the country of their birth wherever possible. Minor physical handicaps not of a progressive nature need not be an obstacle to intercountry adoption. Adoptive parents should be free from severely incapacitating physical handicaps but the recommendation does not rule out physically handicapped adults emotionally well adjusted to their disability. A 7-page bibliography is included.

Issues of *Internatl. Child Welfare Rev.* on special subjects may be ordered from International Union for Child Welfare, 1, rue de Varembé, Geneva, Switzerland, at Sw. frs. 3 per copy.

CHRONIC DISEASE—NURSING CARE

See 676.

CHRONIC DISEASE—RECREATION

690. Chalmers, Constance *(Rancho Los Amigos Hosp., Downey, Calif.)*

Recreation in a chronic disease hospital. *Hospitals.* Aug. 1, 1961. 35:15 (Part I):44-46.

The program department of Rancho Los Amigos Hospital, responsible for patient recreation activities, co-ordinates volunteer services, craft program, service programs of community groups, entertainment, and the patient participation program. Each activity is described, showing how it relates to the diversional therapy program. The patient participation program is approved wholeheartedly by administrators and departments of Rancho Los Amigos, as a means for improving services and as a real contribution to patient morale.

CHRONIC DISEASE—SOCIAL SERVICE

See 666.

COLOSTOMY

691. Barter, R. W. *(Isle of Thanet Group of Hospitals, Kent, Eng.)*

The rehabilitation of ileostomists. *Rehabilitation.* Apr.-June, 1961. 37:25-30.

Public education can insure social acceptance of the patient with an ileostomy who needs the help and encouragement other groups of the disabled receive. The patient should be given a clear understanding preoperatively of what his life will be like after the operation. Dr. Barter discusses the value of postoperative treatment in a rehabilitation unit, complications of ulcerative colitis and of the ileostomy, types of commercial appliances available in Great Britain (with names and addresses of manufacturers), and the domestic and occupational problems involved, following discharge from the hospital.

DEAF—ETIOLOGY

692. Fisch, L. *(Audiology Unit, Heston, Middlesex, Eng.)*

Hyperbilirubinaemia and perceptive deafness, by L. Fisch and A. P. Norman. *Brit. Med. J.* July 15, 1961. 5245:142-144.

In same issue: Jaundice and deafness (an editorial). p. 162-163.

Full assessment of hearing in 50 children, jaundiced at birth, who had had regular daily estimations of total bile pigments and conjugated bilirubin, revealed 6 with

a typical perceptive partial deafness. Findings show a characteristic type of perceptive deafness may occur in jaundiced babies in the absence of athetoid cerebral palsy. It is believed that hyperbilirubinemia alone may not have been responsible for the partial deafness; overdosage with vitamin K may have been partly responsible. Other unsuspected circumstances may have contributed to damage resulting in deafness. Research studies suggest that Synkavit may uncouple oxidative phosphorylation, the same activity bilirubin is known to possess. If it can be shown to do the same in animals as in work with bacteria, it might explain the damage that the combination of bilirubin and vitamin K may produce.

The editorial (p. 162) notes that 30 years ago neonatal jaundice was regarded as a harmless condition except when due to congenital obliteration of the bile ducts. Present understanding of brain damage that can be caused dates from discovery in 1940 of the Rh factor and its role in the etiology of hemolytic disease. In the absence of a clear guide to treatment of jaundiced premature babies, physicians should be aware of the possibilities of deafness and the need for detecting it as early as possible.

DEAF—PARENT EDUCATION

See 674.

DENTAL SERVICE

See 670.

DRAMATICS

693. Verhaeren, Mary

Introducing Fantasia, by Mary Verhaeren and Andrée Serverius. *Rehabilitation.* Apr.-June, 1961. 37:37-41.

Two Belgian women, with disabilities from poliomyelitis, became so fascinated with puppetry in their occupational training that they joined forces to operate a puppet show of their own. Now, several years later, they are nationally recognized, appear on TV and at public schools, and this summer will open their own theater, giving four performances a week from May till September. Complete with illustrations, the article charmingly discusses rehabilitation aspects of puppetry and envisions the day when every rehabilitation center will have a puppet theater!

EMPLOYMENT—ISRAEL

694. Israel. Ministry of Labour

The employment of the handicapped in Israel. *Internatl. Labour Rev.* June, 1961. 83:6:602-611.

The summary of the first report of a committee appointed in January, 1960, by the Ministry of Labour of Israel. The committee found that, of the registered handicapped, 70% were judged capable of rehabilitation; care of the remaining 30% should be removed from the employment service and transferred to other agencies. Data are given on characteristics of handicapped, by degree of disability, size of family, and number in normal employment and in workshops. Recommendations were made on administrative practices of medical examination and selection; reduction of number of disabled on relief works; adult vocational training; legislation and priorities; and possible transfer of workshops to private enterprise. Action to implement the recommendations is outlined.

EPILEPSY

695. Livingston, Samuel *(Dept. of Pediatrics, Johns Hopkins Univ. School of Medicine, Baltimore, Md.)*

Living with epileptic seizures. *J. Pediatrics.* July, 1961. 59:1:128-137.

Social, psychological, educational, vocational, and health problems of the 85% of patients with epilepsy whose seizures are controlled or who have infrequent seizures are discussed, with recommendations for treating such patients. The paper reviews the physician's role in advising parents and child, and advice to be given on daily living activities, maintenance of health, vocational choice, driving an automobile, and the advisability of marriage and parenthood. From experience at the Children's Epilepsy Clinic, Johns Hopkins Hospital, Dr. Livingston is well acquainted with problems confronting the patient with epilepsy.

EPILEPSY—EMPLOYMENT

696. Forrest, John W. *(U.S. Off. of Vocational Rehabilitation, Region IV, Atlanta, Ga.)*

Epileptics need not apply. *J. Rehab.* July-Aug., 1961. 17:4:21-23, 40-43.

As former chief of epileptic services and supervisor of special disabilities, Georgia Department of Vocational Rehabilitation, Mr. Forrest is thoroughly acquainted with the medical, social, and vocational problems of rehabilitating persons with epilepsy. Counselors with little knowledge of the medical treatment of seizures, of family and community attitudes toward the epileptic, of psychological reactions of the client toward his condition, and of factors to be considered in job placement will want to read this highly informative article.

697. Lione, John G. *(Humble Oil and Refining Co., P.O. Box 551, Baton Rouge, La.)*

Convulsive disorders in a working population. *J. Occupational Med.* Aug., 1961. 3:8:369-373.

In a combined population of 9,600 employees at 2 oil refineries, 58 cases of persons with a definite history of convulsive seizure or loss of consciousness were reported. Dr. Lione analyzed data on employment, job placement, accident experience, and absenteeism in the epileptic group. Prevalence rate in this study, 6 per 1,000, parallels closely the prevalence of epilepsy in the general population—about 5 per 1,000. Sickness absenteeism was found to be average or better in 81% of the group. Fear of an increased accident rate among epileptics does not appear justified. The epileptic who conceals his medical condition in a preplacement examination and is placed without work restrictions, as well as the worker developing epilepsy during course of employment, is industry's problem. The industrial physician can help in assuring productivity by proper evaluation of employees' health and by recommendations for proper placement.

EXERCISE

698. Gersten, Jerome W. *(4200 E. Ninth Ave., Denver 20, Colo.)*

Isometric exercises in the paraplegic and in the patient with weakness of quadriceps and hamstrings. *Arch. Phys. Med. and Rehab.* July, 1961. 42:7:498-506.

Earlier studies, proving isometric exercises can produce increase in muscle strength and endurance, raised the question of the nature of the mechanism involved and the ability of patients to respond satisfactorily to isometric exercises. This paper deals with research on the effect of both isometric and isotonic exercises on muscle function in upper and lower extremities. Improvement in muscle was found to be essentially the same after isotonic or isometric exercises; where significant differences were noted, they were always in favor of isometric exercises. In quadriceps and hamstrings, increase in muscle function continued during the entire study but magnitude of increase was almost twice as great in the triceps. Factors thought to be contributory to differences found in the two groups of muscles were studied but no satisfactory conclusion was reached.

699. Müller, E. A. *(Max-Planck Institut für Arbeitsphysiologie, Rheinlanddamm 201, Dortmund, Germ.)*

The physiological requirements for muscle training. *German Med. Month.* June, 1961. 6:6:197-199.

A report of a long-term research project conducted by the author since 1953 to determine 1) minimum degree of activity necessary to prevent muscular atrophy and 2) factors in muscle training producing increase in muscle strength. Experiments on muscle atrophy show that a bedridden patient whose cardiovascular system and metabolism have been spared can be protected from generalized muscular atrophy by once-daily contraction of all muscles to the extent of one fifth of maximum possible contraction. Investigations show a large number of patients can be readily trained to attain the greatest possible increase in muscle strength by a single, short daily contraction of 40% of the strength of maximum possible contraction. Advantages of short training periods with isometric contractions, used in rehabilitation programs, are discussed.

HARD OF HEARING—SPECIAL EDUCATION

See 672; 674.

HEAD INJURIES

700. Lewin, Walpole *(Radcliffe Infirmary, Oxford, Eng.)*

Head injuries and the physiotherapist. *Physiotherapy.* June, 1961. 47:6:154-158. Congress Lecture and Demonstration.

Despite the high mortality from head injury, it should be emphasized that over 90% of those suffering head injury should make a satisfactory recovery if an active rehabilitation program is planned along with immediate treatment. Discussed are cerebral concussion, disabilities following head injury, skull fractures, complications of intracranial infection and cerebral compression, and severe brain injury with prolonged unconsciousness. Early nursing care and physical therapy in the management of such patients are considered; it is important to remember that many patients with head injury also sustain injury to other body parts. In such case, considerable change may be required in nursing and physical therapy technics.

HEREDITY

701. McKusick, Victor A. *(Div. of Med. Genetics, Dept. of Med., Johns Hopkins Univ. School of Med., Baltimore, Md.)*

Medical genetics, 1960. *J. Chronic Diseases.* July, 1961. 14:1:1-198.

Entire issue devoted to the annual review of the literature.

The third annual review of literature on medical genetics, it covers books, symposia and congress reports, and periodical articles published in 1960. A few publications dated 1959, received too late for last year's review, are included. Format is the same as in the 1958 and 1959 reviews (see *Rehab. Lit.,* Apr., 1960, #254, and Oct., 1960, #741). In this year's issue, Section VIII (p. 59-66) covers congenital malformations.

HOMEBOUND—EMPLOYMENT

See p. 262.

HOMEBOUND—PROGRAMS

702. Cherkasky, Martin

Guide to organized home care, by Martin Cherkasky, Isadore Rossman, and Peter Rogatz. Chicago, Hospital Research and Educational Trust, 1961. 35 p. Spiral binding.

Based on principles and procedures reflecting 13 years' experience and achievement with a home care program administered by New York City's Montefiore Hospital, this guide recounts background information and rationale of home care programs. Treatment provided by the hospital, illustrated by 10 selected case histories, and organizational patterns ranging from simple to complex are described. Greatest value of home care is service to the chronically ill, rather than the acute, patient; the community, the family, and the patient benefit economically, medically, and socially. Home care provides the best method of caring for properly selected patients.

Issued by Hospital Research and Educational Trust, 840 N. Lake Shore Dr., Chicago 11, Ill.

MENTAL DEFECTIVES

See 670.

MENTAL DEFECTIVES—EMPLOYMENT

See p. 272.

MENTAL DEFECTIVES—ETIOLOGY

See 713; 714.

MENTAL DEFECTIVES—PARENT EDUCATION

703. Bryant, Keith N. *(Children's Service, Menninger Clinic, Topeka, Kan.)*

Helping the parents of a retarded child; the role of the physician, by Keith N. Bryant and J. Cotter Hirschberg. *Am. J. Diseases of Children.* July, 1961. 102:1: 52-66.

Two psychiatrists offer advice to physicians on how to help parents and when to decide to refer parents to a psychiatric clinic for more comprehensive diagnosis, treatment, and training of the child. Suggestions on conducting the initial diagnostic study, recommendations to parents, the problems to be considered in guidance, and attitudes of parents that must be overcome tactfully are discussed. 55 references.

MENTAL DEFECTIVES—PROGRAMS

704. Dybwad, Gunnar *(386 Park Ave. S., New York 16, N.Y.)*

Rehabilitation for the adult retardate. *Am. J. Public Health.* July, 1961. 51:7:998-1004.

Dr. Dybwad believes too much effort in the past was concentrated on developing classifications of mental retardation based on preconceived notions that defined the retardate's limitations; programs were then planned to fit classifications. Research shows even the severely retarded child has distinct growth potential. Experience with sheltered workshops for the mentally retarded shows that group guidance and counseling aid clients to move toward job placement in the community. Dr. Dybwad believes public health and community agencies should contribute to the wide variety of services needed by adult retardates. Much public education is needed to overcome prejudices and prejudgments against the retarded child and young adult.

MENTAL DEFECTIVES—PSYCHOLOGICAL TESTS

705. Stott, D. H. *(Glasgow Univ., Glasgow, Scot.)*

I.Q. changes among educationally sub-normal children. *Special Education.* June, 1961. 50:2:11-14.

To determine IQ of 952 mentally subnormal children in special schools throughout England (except London and the Bristol region), the Terman-Merrill test was administered, in most instances; results of more than one test were compared. The same wide variation in IQ, found in previous testing of children in the Bristol area, appeared to be general throughout the country. Gains and losses in individual IQ's were much larger than those reported by Terman and Merrill as typical of subnormal children. Possible causes for variations are discussed; when studied in detail, however, they suggest real changes in children's ability. A large number gained in IQ in contradiction to the over-all tendency to lose. The Bristol Social Adjustment Guides have been used, along with intelligence tests, in general assessment of mentally subnormal children, to diagnose maladjustment and measure progress in overcoming it while in special schools. For information on the Guides, write to the author, Department of Psychology, Glasgow University.

MENTAL DEFECTIVES—SPECIAL EDUCATION

706. Karnes, Maxine

The most unusual job on earth; teaching educable mentally retarded junior high school students. *Texas Outlook.* Aug., 1961. 45:8:10-12.

In same issue: A life worth living, LaNelle Boldt. p. 13, 31.—What is a normal child? W. Alexander Hunter. p. 14-16.

Mrs. Karnes's article and the one by Miss Boldt both emphasize that the retarded child can be taught and eventually can take his place in the community as a self-disciplined, socially accepted adult. Mrs. Karnes discusses lesson plans adapted to daily needs of the educable mentally retarded, technics found successful, enrichment material and teaching aids, and the individual attention given to each child's problems. Interest and aid of regular class teachers have been enlisted and people with special ability and talent in the community have contributed to enrichment of the curriculum. She believes strongly that such children should become more a part of the school, with the privilege of attending home economics, shop, music, and art classes if interest and ability indicate they might profit. Miss Boldt, co-ordinator of special education in Tyler (Texas) schools, pleads for acceptance of the retarded child in the school and community. Kindness and patience are needed to teach discipline and develop feelings of confidence and security; programs can succeed only if the public supports and understands special services needed.

Dr. Hunter *(Pan American Coll., Edinburg, Tex.)* urges more care in use of the term "normal" in judging children; the concept is arbitrary and dangerous if parents and teachers fail to recognize that children possess natural differences.

Single copies of *Texas Outlook,* official publication of the Texas State Teachers Assn., are available from The Editor, 316 W. 12th St., Austin, Tex., at 50¢ a copy.

MENTAL DISEASE—EMPLOYMENT

707. Wadsworth, W. V. *(Cheadle Royal Hosp., Cheadle, Cheshire, Eng.)*

Employability of chronic long-stay patients, by W. V. Wadsworth, R. F. Scott, and B. W. P. Wells. *Rehabilitation.* Apr.-June, 1961. 37:5-9.

Employability of long-stay psychotic patients (12 schizophrenics with an average of 17 years' hospitalization who had never experienced work in a sheltered workshop) was studied in relation to work performance of 12 normal subjects recruited through industrial channels. Evaluations of behavior and production show that schizophrenic patients can respond excellently to various normal incentives. Patients made realistic adjustment to reality situations; assimilation of patients with normal workers caused no distress to the latter. There was no need for medical/nursing supervision during the working day. Production was closely related to intelligence in both groups. Fatiguability, often ascribed to chronic schizophrenics, was not evident to any marked extent, contradicting belief that such patients can be effective only over short periods of time.

MENTAL DISEASE—MEDICAL TREATMENT

708. Great Britain. Ministry of Health

Leucotomy in England and Wales, 1942-1954, by G. C. Tooth and Mary P. Newton. London, H. M. Stationery Off., 1961. 36 p. tabs. *(Reports on Public Health and Medical Subjects, no. 104)*

A follow-up survey of 10,365 patients, each of whom received a single lobotomy operation in the period 1942-1954, provided data on patient characteristics, types of illness, operations performed, and length of hospital stay. Clinical gradings, obtained for 6,410 patients, indicated 36% of men and 44% of women showed great improvement following surgery, with improvement most marked among the affective group and least among schizophrenics. Although difficult to assess objectively, incidence of undesirable side effects of surgery may account for decreased use of lobotomy in the treatment of mental disorders. An editorial, summarizing results reported in

the pamphlet and discussing current use of surgery in cases of chronic mental illness, appears in the June 24, 1961, issue of *Brit. Med. J.* (5242:1814-1815).

Available in the U.S. from British Information Services, 45 Rockefeller Plaza, New York 20, N.Y., at 50¢ a copy.

MENTAL DISEASE—PROGRAMS

709. Richman, Sol *(5 Bortner Ave., Delmar, N.Y.)*

Community concern held key to improved DVR services for ex-mental patients. *J. Rehab.* July-Aug., 1961. 17: 4:28-29.

An article by Simon S. Olshansky critically analyzing the state-federal rehabilitation program in relation to ex-mental patients (see *Rehab. Lit.*, Jan., 1961, #56) caused a lively response from readers of the *Journal*. Mr. Richman challenges several of Mr. Olshansky's statements and offers an evaluation of problems encountered in rehabilitating ex-mental patients. He notes adverse and apathetic community attitudes toward provision of adequate services that hamper efforts of state vocational rehabilitation agencies. The *Journal* invites further discussion on the controversial issues.

See also 664; 668; 725.

MENTAL DISEASE—SOCIAL SERVICE

710. Lucas, Leon *(School of Social Work, Wayne State Univ., Detroit, Mich.)*

The Detroit Group social activity for convalescing mental patients. *Public Health Rep.* June, 1961. 76:6:475-480.

A report of a demonstration project sponsored by United Community Services of Metropolitan Detroit, the local health and welfare agency council, and the McGregor Fund, a private foundation, from October, 1954, to December, 1957. Records of 96 persons were used to study behavioral responses to group activity. Evaluation of the outcome of participation was made on a sample of 33 who attended sessions during the third, and last, year of the project. Data are given on patient characteristics, reasons for absences, preferred activities, help and sources of help received from group sessions, and relatives' responses to the program. Conclusions and recommendations for the organization of social activity groups for such patients are included. This paper is based on a detailed report, *The Detroit Group; an evaluative study of a social activity group for convalescing mental patients.* prepared in 1959 for and issued by United Community Services of Metropolitan Detroit, 51 W. Warren Ave., Detroit 1, Mich.

MUSIC THERAPY

711. Alvin, Juliette *(Society for Music Therapy and Remedial Music, London, Eng.)*

Music therapy and the cerebral palsied child. *Cerebral Palsy Bul.* 1961. 3:3:255-262.

Music therapy can be a useful adjunct to physical therapy, speech therapy, and psychotherapy in the treatment of the cerebral palsied. Research on the relationship between medical diagnosis of different types of cerebral palsy and reactions of the patients to music might prove valuable. An experiment conducted by Dr. Erwin H. Schneider, University of Tennessee, is cited. The author has found that the emotional impact of music can act as a definite stimulus to the mind, aiding development of sensory perception and mental activity. In remedial education, music has already made positive contributions and is used increasingly in special schools and centers in England and abroad.

712. Sommer, Dorothy Twente *(Saskatchewan Hosp., Weyburn, Sask., Can.)*

Music in the autobiographies of mental patients. *Mental Hygiene.* July, 1961. 45:3:402-407.

In autobiographies 14 authors who had been patients in mental hospitals during the past century or had been treated by a physician for mental illness describe experiences with music while ill, revealing both negative and positive values of musical experience. Mrs. Sommer, director of music therapy, Saskatchewan Hospital, analyzes experiences in terms of the authors' diagnoses of their mental illness and types of experience. Music had individual meaning for each, reinforcing the belief that music therapy cannot be prescribed by diagnosis.

NURSING

See 669.

NUTRITION

713. Hsia, David Yi-Yung *(Children's Memorial Hosp., 707 W. Fullerton Ave., Chicago, Ill.)*

The metabolism of indole-compounds in phenylketonuria, by David Yi-Yung Hsia and Irene Huang. *Cerebral Palsy Bul.* 1961. 3:3:237-243.

In same issue: Phenylketonuria; clinical aspects, Brian H. Kirman, p. 244-248.—Tests for phenylketonuria, L. I. Woolf, p. 249-254.

The cause of mental defect in phenylketonuria is still unknown; despite extensive studies there is no clear evidence that any of the phenolic derivatives of phenylalanine, or phenylalanine in itself, acts as a "toxic" substance on the brain. In metabolic research studies reported here the authors speculate on the possible role of indole compounds in causing mental deficiency in developing infants. 26 references.

Dr. Kirman *(Fountain Hosp., London, Eng.)* discusses difficulties in diagnosing phenylketonuria in the absence of reliable physical signs. The only method of discovering early cases is through routine testing; the condition can be readily identified in affected families and carriers are identifiable. Treatment by diet should start at an early age even though results obtained thus far require further validation. Diet instructions and advice to be given parents are discussed.

Dr. Woolf *(Radcliffe Infirmary, Oxford, Eng.)* gives detailed instructions for tests to detect phenylpyruvic acid in the urine of infants. He recommends testing of all newborn infants, all mental defectives, and infants who have sibs known to have the condition. Ideally, testing should occur when infants are 2 weeks old and again at 6 weeks. It might also be wise to test all psychologically disturbed or epileptic children, he believes.

714. U.S. Children's Bureau

Phenylketonuria; an inherited metabolic disorder associated with mental retardation, by Willard R. Centerwall and Siegried A. Centerwall. Washington, D.C., Govt.

Print. Off., 1961. 28 p. figs., tabs. *(Children's Bur. publ. no. 388)*

An explanation of the incidence and genetics, biochemistry, and clinical course of a recently discovered disease that, left untreated, results in mental deficiency. Approaches to screening, early detection, and treatment are discussed; the section on testing methods is adapted from an article in the Nov., 1960, issue of *Am. J. Public Health* (50:11:1667-1677). Dietary treatment and low phenylalanine menus are covered. Appendixes contain a list of several medical centers in the U.S. that process tests when local facilities are unavailable and diet-exchange lists for low-phenylalanine diet. Bibliography of 56 references, with several additional references for lay persons and parents. (For other articles by the authors on the subject, see *Rehab. Lit.*, May, 1960, #359, and Mar., 1961, #204.)

Available from U.S. Superintendent of Documents, Government Printing Office, Washington 25, D.C., at 15¢ a copy.

See also 676.

OLD AGE—EMPLOYMENT—GREAT BRITAIN

715. National Old People's Welfare Council (Gt. Brit.)

Employment and workshops for the elderly. London, Natl. Council of Social Service (1961). 15 p. *(Ref. no. 604)*

Workshop schemes of industrial firms or voluntary organizations provide continued employment for workers beyond normal retirement age in Great Britain. Described are types of work offered, pay scales, physical facilities, placement services, and costs of financing. Examples are included of independent, self-supporting workshops and those administered with grants-in-aid. Also contains a brief bibliography, the income and expenditure accounts of one year's operation of an East London workshop, and a directory of workrooms run by voluntary organizations.

Available from National Council of Social Service, 26, Bedford Square, London, W.C. 1, England, at 1s (18¢) a copy.

OLD AGE—MEDICAL TREATMENT

716. Gordon, Edward E. *(Michael Reese Hosp., 2839 Ellis Ave., Chicago, Ill.)*

Rehabilitation of the chronically ill aged. *Ill. Med. J.* June, 1961. 119:6:368-372.

Results of a recent geriatric pilot project emphasize the effectiveness of rehabilitation on nursing home patients admitted to a hospital. When hospitals provide early, preventive rehabilitation and some degree of training in self-care, many elderly persons can be returned to the community. Where physical and occupational therapy is not available in the hospital, interested nurses under supervision of attending physicians can manage the majority of disabled older patients. A progressive plan for management of acute and early convalescent stages of illness in 3 common motor disorders is outlined. Nursing homes, home care services, and outpatient clinics can co-operate in community rehabilitation programs for the older age group.

OLD AGE—OCCUPATIONAL THERAPY

717. Andrews, Gillian M. *(Edgware Gen. Hosp., Edgware, Middlesex, Eng.)*

Group occupational therapy in a general hospital. *Occupational Ther.* June, 1961. 24:6:30-36.

Until March, 1960, conventional methods of teaching geriatric patients at the bedside were used but progress of patients was slow with motivation lacking. A group therapy project involving production-line work proved more effective in promoting social reintegration and preventing both mental and physical deterioration.

OLD AGE—SOCIAL SERVICE

718. Goldmann, Franz *(Harvard School of Public Health, Boston, Mass.)*

Social service in homes for the aged. *Public Health Rep.* July, 1961. 76:7:625-629.

Data on employment of social workers in 70 Jewish homes for the aged in the U.S. and Canada are analyzed by number employed, size of homes employing full-time social workers, their functions and specific activities, and observations on limitations of their work. The development of standards to guide homes for the aged wishing to extend and improve their social services is needed. This article is one of a series by Dr. Goldmann on findings of the over-all studies. (For others, see *Rehab. Lit.*, Feb., 1961, #142.)

ORTHOPEDICS

See 669.

PARALYSIS AGITANS—PHYSICAL THERAPY

719. Wessman, Henry C. *(Bethesda Hosp., 320 S. Hubbard St., Crookston, Minn.)*

Follow-up of a pallidotomy patient. *Phys. Therapy Rev.* July, 1961. 41:7:520-521.

The case history of a 51-year old male with longstanding postencephalitic Parkinson's disease whose chief disability was a general cog-wheel rigidity and contractures, particularly of the right upper extremity. Right pallidotomy resulted in complete relief of rigidity of left extremities; excellent immediate postoperative results followed left pallidotomy. A few hours after surgery, however, he exhibited a severely depressed level of consciousness, right hemiplegia, and pseudobulbar palsy. This article discusses physical therapy technics used in his retraining. Independent ambulation was eventually achieved and complete self-care is now possible. There is even hope he may be able to accomplish simple vocational tasks.

PARAPLEGIA

See 684; 698.

PARENT EDUCATION

720. Auerbach, Aline B. *(Child Study Assn. of America, 9 E. 89th St., New York 28, N.Y.)*

Group education for parents of the handicapped. *Children.* July-Aug., 1961. 8:4:135-140.

Describes a demonstration program to train social work-

ers in group education for parents of handicapped children, conducted by the Child Study Association of America. Comparison of group sessions with parents of well children with sessions for handicapped children's parents reveals that the latter express greater intensity of feeling over their problems, presenting leadership problems. Other variations in group movement are found in groups composed wholly of parents of children with different disabilities or children with similar disability but a wide range of impairment. Such groups work at a slower pace and require unusually sensitive leadership. Observations on technics and social workers' reactions to group work are given. (For further discussion of parent group education, see also *Rehab. Lit.*, Apr., 1961, #256 and 298.)

PARTIALLY SIGHTED—SPECIAL EDUCATION

721. National Society for the Prevention of Blindness *(1790 Broadway, New York 19, N.Y.)*

Guidance and counseling of partially seeing children. *Sight-Saving Rev.* Summer, 1961. 31:2:114-117.

A panel discussion presented at the 1961 annual conference of the National Society for the Prevention of Blindness. Dr. William M. Cruickshank, director of education for exceptional children, Syracuse University, discussed simple tests used in determining individual problems and potentials of partially seeing children. Other panel members covered the supervisor's responsibilities, guidance and counseling programs for elementary school children and high school students, and use of rehabilitation resources within the community. Emphasis was on early referral of partially seeing children for rehabilitation planning.

PHYSICAL EFFICIENCY

722. Assessment in cerebral palsy; discussion at a joint meeting of the Medical Advisory Committees of the N.S.S. and B.C.W.S., at The Hospital for Sick Children . . . London. *Cerebral Palsy Bul.* 1961. 3:3:271-280.

General principles in assessment, difficulties in evaluating results of treatment, and problems in relating results of assessment to therapy were discussed by main speakers at the joint meeting, held in February, 1961. Dr. K. W. Nicholls Palmer, director of physical medicine, Colchester Group Hospitals, stated that one should know what was being assessed and why, since the purpose of the assessment might differ from person to person. Dr. Alexander Innes, orthopedic surgeon, Birmingham's Children's Hospital, discussed factors affecting performance of children and how they might influence assessment of the response to treatment. Dr. P. Hume Kendall, physical medicine department, Guy's Hospital, London, reviewed several proven systems of assessment illustrating practical difficulties in relating results to therapy. Talks were followed by a general discussion on use of films for recording progress, numerical charting, the value of physical therapy, and possible use of the Pulheems system for assessment.

PSYCHOLOGY

723. Richardson, Stephen A. *(Assn. for the Aid of Crippled Children, Rm. 700, 345 E. 46th St., New York 17, N.Y.)*

Cultural uniformity in reaction to physical disabilities, by Stephen A. Richardson (and others). *Am. Sociological Rev.* Apr., 1961. 26:2:241-247.

An earlier pilot study of children's categories of interpersonal perception (1957) showed a consistent preference pattern in their evaluation of various physical disabilities. The current paper reports a replication of the study to determine consistency of the finding in children with widely diverse backgrounds. Possible explanations for the remarkable degree of uniformity found in the present study are considered. Composition of the 6 sets of children tested is described; in all sets the drawing of the able-bodied child was ranked first by both handicapped and nonhandicapped children. The question is posed of how this behavior could have been learned; possible effect of publicity materials of national health organizations on children's preferences is suggested.

See also 671; 731.

PUBLIC HEALTH NURSING

724. Saunders, Ethel *(Salt Lake City Dept. of Public Health, Salt Lake City, Utah)*

The public health nurse's role in rehabilitation, by Ethel Saunders and Chester A. Swinyard. *Nursing Outlook.* July, 1961. 9:7:426-427.

The nursing rehabilitation program of the Salt Lake City Department of Public Health offers an excellent means for casefinding and for continued follow-up of patients discharged from hospitals. Patients needing continued or additional services are referred to their own physician, who evaluates problems and makes further plans for treatment. Since community rehabilitation programs are relatively new, the role of the public health nurse is just beginning to be defined.

RECREATION

See 667; 673.

RECREATION—PERSONNEL

725. Ackerman, Ora R. *(Evansville State Hosp., Evansville, Ind.)*

Coordination of activity therapy, a new career opportunity for professional recreation personnel. *Recreation for the Ill and Handicapped.* July, 1961. 5:3:6-8, 16.

In same issue: Activities therapies and voluntary services, Department of Mental Hygiene and Correction, Ohio Division of Mental Hygiene, Thomas J. Clark. p. 10-12, 17.

Co-ordinators of activity therapy programs are found mainly in local hospitals but may be working at the state level, especially in governmental units having strong mental health departments. Responsibilities lie in the areas of hospital administration, human relations, and public relations. The co-ordinator may be responsible for administration of a program including recreational, occupational, music, industrial, corrective, manual arts, and educational therapies and volunteer services. Advantage of co-ordinating departments under one head lies in the reduction of shuttling patients from department to department. Co-operation makes wider variety of programs possible; staff and patient morale is improved; overlap-

ping of services is eliminated; and volunteer services are used to better advantage. The paper was presented at the National Congress in Chicago, September, 1959.

Mr. Clark *(Div. of Mental Hygiene, State Office Bldg., Columbus 15, Ohio)* is co-ordinator of activities therapies and voluntary services in Ohio's mental hygiene program; his talk at the seventh annual physical medicine and rehabilitation conference, September, 1960, in Chillicothe, Ohio, discussed administration of programs, providing services in hospitals for the mentally ill and in institutions for the mentally retarded.

RED CROSS. BRITISH RED CROSS

726. Bridgewater, Jean

The work of the British Red Cross in the field of rehabilitation. *Rehabilitation.* Apr.-June, 1961. 37:31-35.

As a voluntary organization, the Red Cross in Great Britain provides auxiliary service mainly to persons included in the Ministry of Labour's category of unemployable. Aim of the Society's work is to facilitate communication between the disabled and state services, making known the financial and physical relief available. Discussed are training of volunteer welfare workers and services provided in hospitals and through home visits, holidays, clubs for the disabled, and training schools for young disabled persons past school age. A mobile exhibit of aids for the disabled, promotion of aid to the mentally ill, and staffing of centers for the blind are among the Society's activities.

REHABILITATION—CALIFORNIA

727. California. Vocational Rehabilitation Service

Survey of cases active December 1, 1960; statistical report, prepared by Julian C. Riley. Sacramento, The Service, 1961. 72 p. tabs., charts. Mimeo.

The third such report since initiation of the Vocational Rehabilitation Service's statistical research program in 1955, this study brings up to date the information on case load characteristics and serves as a basis for comparison with earlier reports (published in June, 1955, and in June, 1956). A review of current case loads, on a sample basis, was made to determine changes in characteristics (especially medical, economic, and social aspects), to evaluate program development and the effectiveness of administrative policies and procedures, and to note types and cost of services. In addition to a summary of the highlights of the survey and a discussion of the information on a statewide basis, the report contains statistical tables, useful for comparing current and previous findings.

REHABILITATION—CANADA

728. Roeher, G. Allan *(416 Health and Welfare Bldg., Regina, Sask., Can.)*

Rehabilitation progress and needs in Canada. *Rehabilitation.* Apr.-June, 1961. 37:17-24.

Rapid growth and expansion toward comprehensive services in all provinces of Canada has been noted during the past 2 decades, reaching a substantial number of the nation's handicapped. Voluntary organizations continue to lead in provision of services to civilians, although most programs are directly or indirectly assisted by public funds. Government provides major support for education and vocational training, development of treatment facilities for the tuberculous, mentally retarded, and mentally ill, hospital-centered rehabilitation centers, and formal co-ordinated programs. Industry supports rehabilitation for the industrially injured through publicly managed Workmen's Compensation Boards. Rehabilitation needs still to be met are discussed and optimum goals may be achieved within the next generation, Dr. Roeher believes. The pattern of provision of services is similar to that observed in the U.S. with some exceptions.

REHABILITATION—SWEDEN

729. D'Avignon, Marcel *(Central Swedish Hosp. and School for Children with Motor Handicaps, Stockholm, Swed.)*

The care of children with motor handicaps in Sweden. *Cerebral Palsy Bul.* 1961. 3:3:216-221.

Administration of medical treatment and provision of education for handicapped children in Sweden is described; since 1950 interest in care of the cerebral palsied has increased, with treatment programs currently being revised. Home care is recommended where possible, with regional and local facilities providing services. There are no special organizations concerned with preschool children with motor handicaps, except for such well-defined groups as the blind, deaf, and cerebral-palsied. Some residential accommodations are available, but what is now needed are nursing homes specifically for chronically ill young people.

REHABILITATION—PERSONNEL

See 724; 725; 732.

SHELTERED WORKSHOPS

See p. 262; p. 272; 673; 715.

SHELTERED WORKSHOPS—PENNSYLVANIA

730. Nye, Richard *(Occupational Services, Inc., Chambersburg, Pa.)*

Mixed disability workshop thrives in small community. *J. Rehab.* July-Aug., 1961. 17:4:10-11, 33, 46.

A description of the facilities and successful operation of Occupational Services, Inc., a small-community workshop accepting all types of disabled persons for vocational rehabilitation. Services offered, types of work, pay schedules, financing costs, results of job placement, and the advantages of a mixed-disability workshop are discussed. Chambersburg has a population of 17,000 and the workshop draws its clients from the 85,000 residents of the area.

SOCIAL SERVICE—CASEWORK

731. White, Esther *(Social Service Dept., Mt. Sinai Hosp., New York, N.Y.)*

The body-image concept in rehabilitating severely handicapped patients. *Soc. Work.* July, 1961. 6:3:51-58.

The concept of body image needs to be more fully understood by those working with the disabled in order to develop improved skills in their treatment. Anxieties and frustrations produced by need for extensive read-

justment physically, socially, and emotionally must be relieved before the handicapped can become productive. Much depends upon the hospital treatment team, the first nonhandicapped group the patient comes in contact with—he will expect to find in the community the same attitudes reflected by hospital staff. The role of the social worker in the treatment program and in working with patients' families is defined.

SOCIAL SERVICE—GROUP WORK

See 667.

SOCIAL SERVICE (MEDICAL)

See 666.

SPEECH CORRECTION

See 672; 674.

SPEECH CORRECTION—PERSONNEL

732. Barton, Richard Thomas *(9730 Wilshire Blvd., Beverly Hills, Calif.)*

Relationships between private practitioners in medicine, speech pathology, and audiology. *Eye, Ear, Nose, and Throat Month.* July, 1961. 40:7:492-493.

Dr. Barton, associate consultant in otolaryngology, University of California, Los Angeles, discusses the common meeting ground of speech pathologists, audiologists, and otolaryngologists who, under usual circumstances, do not duplicate each other's services. Greater specialization, however, and division of practice pose problems. He discusses qualifications the speech pathologist and/or audiologist should, ideally, have; only through private practice will they overcome their subsidiary or ancillary role in medical care and rehabilitation, he believes. If graduate work in both fields were more closely co-ordinated with medical school programs of otolaryngology, division of responsibility would be more widely understood. The controversial issue of responsibility for selection and fitting of hearing aids is discussed.

STUTTERING

733. Johnson, Wendell

Studies of speech disfluency and rate of stutterers and nonstutterers, by Wendell Johnson (and others). Washington, D.C., Am. Speech and Hearing Assn., 1961. 82 p. figs., tabs. *(J. Speech and Hear. Disorders, Monograph suppl. 7,* June, 1961)

The five studies reported here were part of a research program designed to develop procedures for measuring disfluency and establish standards of reference provided by relevant normative data.

Contents: Introduction, Wendell Johnson.—Measurements of oral reading and speaking rate and disfluency of adult male and female stutterers and nonstutterers, Wendell Johnson.—Reliability of the Iowa Speech Disfluency Test, Eric K. Sander.—Predicting ratings of severity of stuttering, Martin A. Young.—Repetitions in the vocalizations and speech of children in the first two years of life, Harris Winitz.—A study of the speech behavior of stutterers and nonstutterers under normal and delayed auditory feedback, James N. Neelley.

Single copies of the *Journal* are available from Kenneth O. Johnson, Business Manager of Publications, American Speech and Hearing Assn., 1001 Connecticut Ave., N.W., Washington, D.C., at $1.90 a copy.

VOCATIONAL GUIDANCE

734. Wright, Robert R. *(Dept. of Special Education, Wayne State Univ., Detroit, Mich.)*

Self-referrals from high school students; a new approach. *J. Rehab.* July-Aug., 1961. 17:4:14-15.

A questionnaire form titled "Student Health Survey" was devised in 1959 by George N. Wright, for use in casefinding in high schools (see *Rehab. Lit.,* May, 1959, #438; also, July, 1961, p. 199). Vocational rehabilitation counselors have used the form successfully, to identify students unrecognized by school personnel as eligible for services. This article suggests adaptations in the self-reporting form and includes a tentative form, the Physical Condition Survey, that would reveal how students perceive their physical condition in relation to vocational potential. The author believes that, for the purpose of casefinding and preliminary identification, observable symptoms and functional limitations are more useful than medical and disease labels.

See also p. 272; 683.

VOLUNTARY HEALTH AGENCIES

See 668.

VOLUNTEER WORKERS

See 726.

WORKMEN'S COMPENSATION—TEXAS

735. Wiener, Frederick *(708 Taum St., Houston, Tex.)*

Texas and workmen's compensation; changes ahead? *J. Rehab.* July-Aug., 1961. 17:4:19-20.

A report of a study by the Vocational Guidance Service of Houston to determine whether workmen's compensation laws make it more difficult for handicapped persons to obtain jobs and whether employers really understand the law. Meetings with attorneys for both management and labor and with representatives of insurance companies revealed interesting comments; the initial investigation clearly indicates reason to believe the law, its provisions, and interpretation adversely affect employment of the physically handicapped. Disadvantages of the humanitarian and public relations approach for increasing employment opportunities are noted. Changes in the law, acceptable to all segments of the community, could provide equalization of opportunity for the disabled.

Events and Comments

Statistics on Health of Aged Issued by U.S. Senate Committee

NOW AVAILABLE is a Committee Print *Health and Economic Conditions of the American Aged; A Chart Book,* prepared for the Special Committee on Aging of the U.S. Senate *(U.S. Govt. Print. Off., Washington 25, D.C., June, 1961. 18 p. 15¢).*

The pamphlet states that, as of December, 1960, almost 17 million persons in the United States were 65 years old or more. Millions of these are reasonably healthy, but others suffer from varying degrees of disease and disability. The National Health Survey showed that three fourths of all aged not in institutions have one or more chronic conditions. Two fifths have a chronic condition that prevents or limits usual activity. About one fifth are confined to the house or have trouble getting around alone. With advancing age the picture worsens. Among those 75 years or older, almost one third are confined to the house or need help getting around outside.

International Prosthetics Course Held in Paris

FROM JULY 3 to 15, about 250 specialists in rehabilitation of the physically disabled from a dozen countries attended the International Prosthetics Course held at the New Medical School of Paris University. Lectures were given by 45 outstanding authorities. The Course was organized by the International Society for Rehabilitation of the Disabled and the World Veterans Federation, under the patronage of M. Raymond Triboulet, French Minister for Veterans Affairs.

Psychological-Vocational Study Of Facially Disfigured Reported

A PROGRESS REPORT of a study begun in September, 1958, is included in the *Annual Report 1960-1961,* Institute of Reconstructive Plastic Surgery, New York University Medical Center. Grants from the U.S. Office of Vocational Rehabilitation made possible this study of "The Contribution of the Team-work Approach to the Rehabilitation of the Facially Disfigured." Project director is John M. Converse, M.D.; project co-ordinator, Mary Stewart, M.S.; and surgical consultant, Ross M. Campbell, M.D.

Until space is available at the new University Hospital, this vocational study is being conducted at the Institute's pilot clinic in Manhattan Eye, Ear and Throat Hospital. Of the 198 patients remaining after withdrawals and drop-outs made because patients were under age 14, 29 percent were classified as having mild disfigurement, noticeable only if attention is drawn to it; 49 percent moderate disfigurement, noticeable but not serious enough to cause others to withdraw; and 22 percent severe, causing strong reactions of pity or revulsion.

Cause of disfigurement was congenital defects in 41 percent, trauma in 45 percent, and disease in 14 percent. The study includes complete medical histories, thorough physical examinations, intensive social service interviews, psychological investigations, and psychiatric evaluations, all done before surgery. Postoperative interviews were held to determine reactions to results of surgery.

Major observations to date are: There is wide discrepancy between the patient's and the surgeon's conception of degree of deformity, those with the least severe disfigurement tending to exaggerate it. The major change reported by patients after operation is increased self-confidence and social ease. Males with minor disfigurements tend to be more neurotic than females in the same groups and are generally less satisfied with results of surgery.

In conjunction with this study, a 25-minute sound film *Second Chance* is to be produced, telling of the rehabilitation of a chemistry teacher disfigured in a laboratory explosion. The purpose is to better the understanding of the meaning of facial disfigurement and the understanding of how victims can be returned to satisfying and productive roles in society. Dr. Converse is medical consultant for this film, for which the U.S. Office of Vocational Rehabilitation has granted $41,227. It is to be distributed by the Society for the Rehabilitation of the Facially Disfigured *(210 E. 64th St., New York 21, N.Y.)* and through film libraries of the OVR and the International Society for Rehabilitation of the Disabled.

NIH Grant Establishes First Center for Study Of Mental Retardation

THE PSYCHIATRIC INSTITUTE of the University of Nebraska will be the location of the first center in the United States for the study of mental retardation. The center is made possible by a grant of $1,745,000 to the University's College of Medicine by the National Institute of Mental Health. A new metabolic laboratory will be built to augment facilities to be located within the Institute.

British To Issue Parking Badge to Disabled Drivers

WELFARE AUTHORITIES in England and Wales have been asked by the Minister of Health to issue free to severely disabled car drivers special car badges so that they may be given police assistance in parking problems. No legal rights are conferred, but the badges will aid police to assist when necessary and to use discretion in the handicapped's favor when possible. The badge is a bright yellow metal disc with appropriate wording.

ICD Names New Directors

ROBERT P. BROWN, Jr., of Alexandria, Va., has been appointed director of patient programs at the Institute for the Crippled and Disabled, New York City, succeeding James N. Burrows, who early this year became Institute director. Mr. Brown was assistant administrator of the Cape Fear Valley Hospital, Fayetteville, N.C. After early work as a physical therapist, Mr. Brown served in various administrative positions in the field of rehabilitation.

Walter S. Neff, Ph.D., was recently named to fill the new position of research director for the Institute. For the past several years, Dr. Neff has been research psychiatrist with the Jewish Vocational Service of Chicago.

A Comment on The Changing Role of Public Institutions for the Retarded

"THERE NOW HAS BEEN some stronger action by parents groups and social agencies to supply facilities in the community. In the next ten years we will see a drastic change in the population of the institution. Many of the educable and trainable will remain in the community with full programs to meet their needs. The institution will receive the severely and profoundly retarded—infants and older—, the hyperactive educable and trainable, the emotionally disturbed and disorganized retardates. In some institutions this will mean that some physical change will have to be made to better care for these residents. Many will have to adopt more protective security units.

Another group that we will have to plan for is the older retardates who have been able to live in the community with a program but who will need supportive, close care as their families dissolve. Residential community centers may be able to meet this need as well as the institution."—*From Guest Editorial by Frank R. Giliberty,* Am. J. Mental Deficiency, *July, 1961, p. 2.*

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